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(In)visible women: a narrative study of larger women's pregnant embodiment and maternal healthcare

Sushila Chowdhry

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Declaration

I confirm that this thesis presented for the degree of Doctor of Philosophy has i) been composed entirely by myself ii) been solely the result of my own work iii) not been submitted for any other degree or professional qualification.

Sushila Chowdhry

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Contents

Abstract

The research on which this thesis is based explores larger women's experience of 'maternal obesity'. My work takes a social constructionist approach to studying experience. This approach has been criticised for privileging the social aspects of embodiment at the expense of the more material, visceral aspects. My contribution addresses this criticism by adopting a novel narrative approach to the study of embodied experience. To do so I draw on writing from the fields of medical sociology, anthropology and bioethics, along with feminist and critical social perspectives to theorise the body as social, cultural, political and lived. At the heart of my work is the desire to examine, in detail, aspects of the 'moral jeopardy' (Murphy, 1999) which larger pregnant women have encountered in healthcare spaces and to explore the ways current obstetric approaches to 'maternal obesity' shape larger women's experiences of pregnant embodiment. By doing so, I make a contribution to knowledge about how the changing embodied experience of pregnancy is shaped by maternal healthcare practices in the context of maternal obesity discourse.

The research is based on repeat in-depth interviews with six women who were medically classified as having 'maternal obesity'. The women were recruited from a single Scottish maternity hospital during the early stages of their pregnancies. The women's experience of pregnancy and childbirth was captured in three interviews over the course of their pregnancy and following childbirth. In order to gain a better understanding of the context in which the women received their care, individual face-to-face narrative interviews were also conducted with key maternal health professionals including five obstetricians, six midwives, and two anaesthetists.

Data were analysed using a two-stage structural narrative analysis involving identifying *how* and *why* particular stories were told in the course of interviews, and exploring the broader narratives drawn on to make meaning in these stories. Following the work of sociolinguist Gee (1999, 2011), particular attention was paid to the ways that characters, situations, actions, and artefacts were framed in the stories. These framings revealed how participants understood their own actions, and those of others, in the context of their stories of experience.

The research findings are presented as a series of composite monologues following the journey women travel through maternal healthcare - from the early stages of pregnancy through to the postnatal period. Presenting the findings in this way illuminates how the context of maternal healthcare configures pregnant embodiment as the pregnancy advances. Each monologue is accompanied by a commentary discussing the main analytical points, engaging with existing literature, and discussing the findings in light of what is known and the contribution made by this research. The findings reveal the complexities of maternal healthcare professional positionality in relation to the larger pregnant body, shaping the practice of these professionals with regard to larger embodiment. The findings further demonstrate that larger women's highly stigmatised and visible bodies render them vulnerable to targeted medical screening which also stigmatises the foetal body. Moreover, this process can serve to silence the women by rendering them somewhat (in)visible.

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This thesis is dedicated to the memory of my mother Christine Chowdhry and my father Inder Sain Chowdhry who I'm sure would have been pleased to have another doctor in the family.

Tables

Appendices

Abbreviations

AMU	Alongside Midwifery Unit
BMI	Body Mass Index
CMACE	Centre for Maternal and Child Enquiries
EBM	Evidence-based Medicine
CTG	Cardiotocography
GDM	Gestational Diabetes
GWG	Gestational weight-gain
GI	Glycaemic-index

HCP	Healthcare Practitioner(s)
HAES	Health at Every Size ®
KCND	Keeping Childbirth Natural and Dynamic
LGA	Large-for-gestational-age
MHC	Maternal Healthcare
MHP	Maternal Healthcare Practitioner(s)
NTD	Neural Tube Defects
OU	Obstetric Unit
OGTT	Oral Glucose Tolerance Test
RAG	Research Advisory Group
RCOG	Royal College of Obstetricians and Gynaecologists
SGA	Small-for-gestational-age
SWHMR	Scottish Women Hand Held Maternity Record

Glossary of terms

Cardiotography	A medical technology used to monitor the foetus' heartbeat and the mother's contractions while the foetus is within the womb (Tiran, 2017).
Gestational hypertension	Raised blood pressure during pregnancy (RCOG, 2018).
Iatrogenic	Illness caused by medical examination or treatment (Illich, 1976).
Instrumental delivery	The use of forceps or vacuum extraction to help deliver a baby during the pushing stages of labour (RCOG, 2018).
Intrapartum	During birth (RCOG, 2018).
Large-for-gestational-age	Foetuses whose growth is above the 90th percentile for their gestational age (Hoff et al., 2009).
Macrosomia	Babies who have a birth weight ≥ 4000g (Boulvain *et al.*, 2016).
Metabolic syndrome	A condition whereby problems metabolising sugar and fat lead to the medical condition of 'obesity' (Boulvain *et al.*, 2016).

Multiparity	A woman who has given birth to more than one child (Tiran, 2017).
Neural tube defects	Problems with the brain, spine and spinal cord, i.e. spina bifida (NICE, 2016b).
Oral Glucose Tolerance Test	A test used to diagnose diabetes in pregnancy involving measuring the level of glucose in the blood after fasting (CMACE/RCOG, 2010).
Parity	The number of times a woman has given birth to a foetus ≥ 24 weeks gestation (Tiran, 2017).
Polycystic ovary syndrome	Polycystic ovary syndrome is associated with irregular menstrual bleeding, excessive body hair, weight-gain, skin problems and the presence of multiple fluid filled sacs on the ovaries (NHS Choices, 2016b).
Postpartum haemorrhage	Heavy bleeding (often from the area where the placenta was attached) after the birth of the baby (RCOG, 2018).
Pre-eclampsia (also known as toxaemia)	A condition occurring in the second half of pregnancy. In severe pre-eclampsia the baby is delivered early (RCOG, 2018).
Pre-term delivery	Delivery before 37 week gestation (RCOG, 2018).
Primigravida	Describes a woman who is pregnant for the first time (Tiran, 2017).
Shoulder dystocia	An emergency situation whereby the baby's head is born but one of the shoulders becomes stuck behind the mother's pubic bone. It requires swift medical response (RCOG, 2018).
Symphysis-fundal height	Fundal height is used to calculate foetal growth during pregnancy and is measured by calculating the distance between the pubic bone and the top of the uterus (Robert *et al.*, 2015).
Thromboembolism	Describes a blood clot often in the veins in the calf and is associated with serious complications such as deep vein thrombosis and pulmonary embolism (a potentially fatal condition) (RCOG, 2018).
Type 1 diabetes mellitus	A lifelong condition where the body fails to produce enough insulin and insulin injections are required to lower blood sugar (NHS, 2018).

Type 2 diabetes mellitus	A condition related to high blood sugar which is believed to be associated with age, ethnicity and body mass. Treated with oral medication and dietary interventions (NHS, 2017).

Key to transcriptions

/	End of a speech spurt, containing a central topic or idea, marked by a short pause and/or a partial fall in pitch (Gee, 2011). (I have left these out of the examples used throughout the thesis to reduce 'clutter' and use a new line to denote the end of a speech spurt).
CAPITALS or <u>underlined</u>	Emphasised words; indicate the new information which is the focus of the speech spurt. The speaker puts stress on the word by changing the pitch of the sentence either up or down (or both), and/or increases volume (Gee, 2011).
//	Indicates the finishing or "closing off" of the speech spurt, marked by a final falling contour (marked fall in pitch) indicates that the speaker has completed the topic.
:	Elongation of parts of a word. Elongating words adds emphasis to the word.
(0.2)	Pause, twice as long as a noticeable pause.
…	Marks the beginning and end of a section of text, which has been taken from another section of the interview but shares the same theme or idea as other sections of text.
{}	Around selected text indicates the participant is doing something else while talking e.g. laughing or whispering.

Chapter 1

> I sat with Anna on the sofa with the digital recorder and a tray of her homemade gingerbread and tea between us. Taking a break from the interview topics we ate our cake and chatted about her recent holiday. In front of the sofa was a small coffee table with a huge bowl of fresh shiny fruit. As we ate our cake the fruit seemed to stare accusingly at us. I contemplate the bowl of fruit which I realise has come to symbolise 'healthy eating' and 'good healthy citizenship'. I wonder if Anna had placed it there to say something to me about herself. I feel self-conscious about my body, my eating, and my role as researcher. In that moment I am aware of how impossibly visible larger people are as targets of anti-obesity discourse.

1.1 Introduction to the research

This thesis is based on research exploring contrasting narratives of 'maternal obesity'. The research draws on sociological, anthropological, feminist and narrative writing and aims to explore the ways healthcare interactions and practices shape the experience of pregnancy in the context of current healthcare policies which identify larger women's pregnancies as 'high-risk'.

'Maternal obesity' is the medical label used to describe women who are defined as 'obese' at the beginning of their pregnancies. Obesity is a medical classification based on a calculation of weight to height ratio (see Section 1.2). The subject of 'maternal obesity' is also a prominent feature of medical, obstetric, midwifery, media and public discourses which position larger pregnant women as irresponsible by placing them, their unborn child and maternal healthcare professionals (MHP) at risk (Blake, 2010). Larger women are therefore constructed within the discourse of maternal obesity as potentially 'bad mothers' (e.g. Pollitt, 1998; Keenan & Stapleton, 2010; McNaughton, 2011; Lupton, 2012a, 2012b, 2013c).

As I will go on to demonstrate in Chapter 2, much of the existing medical knowledge concerned with 'maternal obesity' draws attention to the 'failings' of larger women's bodies over the course of pregnancy and childbirth. In contrast little is known about the experience of 'maternal obesity' from women's perspectives. There is also a lack

of research exploring pregnant embodiment and maternal healthcare (MHC) from a sociological perspective, taking account of the context in which the experience of pregnancy is shaped. This research aims to address this gap; making a contribution which illuminates the ways current obstetric approaches to 'maternal obesity' shape larger women's experiences of pregnant embodiment.

The research on which the thesis rests comprises a narrative study involving repeat, in-depth interviews with 6 pregnant women who were medically classified as having 'maternal obesity' and were expecting their first child. Each woman took part in 3 interviews, 2 during pregnancy and a final one 2-7 months after the birth of their baby. The women's experiences were contextualised by in-depth interviews with 6 midwives, 5 obstetricians and 2 anaesthetists at a single site in Scotland. The study addresses the research question: how do larger women experience pregnant embodiment, childbirth and maternal healthcare in the context of 'maternal obesity'? In order to understand further how larger women are understood in MHC spaces, the research also addresses the following sub questions: how do MHP frame and represent the larger women they care for? And: what do these framings reveal about the context in which larger women experience maternal healthcare? The research makes a knowledge contribution about how medical practices and MHC institutional discourse and practices shape larger women's experience of their bodies, pregnancies and childbirth.

1.1.1 Evolution of my approach to larger pregnant embodiment

My interest in conducting this research was initially stimulated by my curiosity about the vast quantity of healthcare literature problematising the large pregnant body. I noted obstetric literature was highly focussed on the issue's obstetricians experienced in managing the larger body in the context of the clinic or labour ward. In contrast, the midwifery literature reflected concerns with drawing attention to women's weight and weight-gain in the context of antenatal care. Furthermore I noted, the basis of much of the obstetric and midwifery literature, foregrounded larger embodiment as simply a problem arising from women's lack of knowledge about nutrition or lack of physical exercise. Therefore, I found, much of the healthcare

literature lacked political engagement, and simply drew attention to the need to provide pregnant women with information about risk so they could respond accordingly by reducing their body size.

My previous role as a public health nurse had sensitised me to the complicated nature of larger embodiment and the difficulties associated with conventional ways of 'dealing' with the large body through population screening, monitoring and intervention. I had been involved in interventions myself in which I was required to identify and refer 'over-weight' children to dieticians for assessment and nutritional advice. The realities of these practices led me to become more critical of the technologies associated with mass screening. For example, after weighing and measuring thousands of primary and secondary school children, I became more aware of the wider issues associated with the BMI as a technology for the classification of the body as abnormally 'fat', or for predicting 'unhealthy' lifestyles. Furthermore, many years of weighing and measuring children and young people had sensitised me to the potentially negative effects of such practices on children's body image and eating practices: particularly at a time in their lives when they were potentially acutely self-conscious.

It was these previous experiences, coupled with my observations about the healthcare approach to the larger pregnant body, which stimulated my interest in more critical ways of understanding larger embodiment. Over the course of my work on this research I have embraced the writing of feminist, poststructural and postmodern authors; the work of narrative researchers; fat activists; critical geographers; and writing from the fields of medical anthropology, medical sociology, and bioethics. All these ways of thinking about the larger pregnant body have helped me to identify my position and approach to larger pregnant embodiment within this research. As I have discovered new lenses to explore and understand the ways larger women are positioned and understood by society, and within maternal healthcare environments, I have also found ways of understanding how medical authority and discourses of risk, anti-obesity, and mother blame act in relation to pregnancy and childbirth.

My reading has also led me to reflect on my own embodiment and in doing so I was able to recognise my own 'struggle' as a woman in terms of maintaining my own

'slim' body and the pleasure I have taken from its lack of adiposity. For example, I have at times in the past ran my hand over my own flat stomach, celebrating how concave it is and praising myself for being able to miss so many meals so easily. I also recognise the struggle I have had in finding alternative discourse with which to find greater self-acceptance for my own ageing and expanding body. I believe it is almost impossible to free oneself from the power these discourses have over women in Western societies. I also recognise all women are subject to discourses of female thinness - irrespective of their size and weight. I recognise this as a motivation for my positioning in this research. However, I appreciate my own experiences are insignificant juxtaposed with women who society identifies as 'fat'.

Through my reading and reflection, I have been able to take these intellectual and empathic understandings to develop an approach to thinking about the larger pregnant body using lenses which are not commonly found within the healthcare context. While my work seeks to explore and discuss larger women's experiences, I am also sympathetic to the responsibilities and challenges faced by practitioners who provide care to larger women. My work aims to provide a greater understanding of larger women and MHP experience of what is currently referred to as maternal obesity in a way which also accounts for the context in which women experience their care.

1.1.2 My epistemological position

The approach I have taken in respect of this research is what could be broadly described as a feminist approach. Feminist research takes many forms and according to Doucet and Mauthner (2006) feminist researchers may resist the notion there are specific feminist methods and methodologies, arguing instead that feminists are: "simply" doing "good" research" (p.40). One way of doing 'good' research is to give attention to the way power figures in the research process, thereby resisting the objectification of research participants (Reinharz, 1979) and patriarchal authority in relation to knowledge creation (Gilligan, 1977). Harding (2004) suggests one way to do this is to privilege women's experiential knowledge rather than seeking 'objective truth'. Women's experiential knowledge is therefore of utmost importance in the context of dominant anti-obesity and 'maternal obesity' discourses, which tend to

draw on a patriarchal medico-moral stance to warrant the castigation of larger pregnant women, leaving little space for counter-knowledges (e.g. LeBesco, 2004; Smith & Sparkes, 2005; Monaghan, 2008; Colls & Evans, 2009).

By taking this view I give primacy to the notion that, in relation to the production of knowledge, marginalised groups by the very nature of their position in society have little opportunity to generate and circulate knowledge 'truth' (Harding, 2004) however, they "hold a particular claim to knowing" (Doucet & Mauthner, 2006: p.36) and therefore, women's experiences are good "places from which to start off knowledge projects" (Harding, 1991: p.61). The concept of marginalisation is a problematic concept in that it tends to construct individuals as less important or valuable. Therefore, following Clark and Sharf (2007) I define marginalisation as "being beneath the public gaze" (p.406). Larger women are, according to Tischner and Malson (2008), and McCullough (2013), highly visible political targets for medico-moral discourse but due to the sociocultural framings of the larger body are simultaneously silenced. It is my aim that this research provides a space in which otherwise ignored voices can be heard.

Feminist epistemology also suggests it is impossible to take an objective value-free approach to research highlighting the need for careful attention to researcher positionality and reflexive processes (Stanley, 1992; Mauthner & Doucet, 1998; Doucet and Mauthner, 2006). As with many qualitative studies, the processes which transform raw data into research findings are most often hidden from the reader and therefore there is a need for "accountable and responsible knowing" (Doucet & Mauthner, 2006: p.41). In response to these considerations I have, firstly, written this thesis from the position of first-person, acknowledging my personal involvement in the research as an actor and a co-creator of knowledge. Secondly, in order to make more transparent my value-base, I have also included reflexive accounts at various stages of the work.

1.2 Language and representation

Within clinical settings the term 'obese' relates to bodies which fall into a category assigned by the calculation of weight to height ratio (kg/m^2) termed Body Mass

Index (BMI) or Quetelet Index (NICE, 2014). Once calculated the body can be categorised according to BMI as in Table 1.1 below:

Table 1.1 Classification of overweight and obesity

Categorisation	**BMI**
Healthy weight	18.5 − 24.9
Overweight	25 − 29.9
Obese	30 − 39.9
Severely obese	≥40

Outwith clinical settings, terminology often also includes various euphemisms for body size including, for example, big, big girl(s), plus-sized and big boned. While these euphemisms may appear gentler than medical terminology (Meadows & Daníelsdóttir, 2016), critical fat scholars suggest that irrespective of how large body size is couched, all terms describing body size typically reflect negative connotations associated with the larger body (e.g. Wann, 2009) and therefore, contribute to the Othering of larger people.

It is clear from the biomedical, psychological, sociological and critical public health literature that various positions may be taken in relation to understanding the larger body; each of these has their own language preferences. Therefore, the choice of language signals author positionality in relation to the assumptions which are made about the 'problem of obesity'. In conducting this research one of my intentions is to avoid making a knowledge contribution which perpetuates the Othering of larger women. Despite engaging with a variety of literature examining the implications of language describing larger body size I have not found a satisfactory solution to my quest for suitable terminology with which I feel fully comfortable.

The terms 'obesity' and 'obese' are central to the medicalisation[1] of body size (Pausé, 2014) and describe bodies which are believed to be unhealthy due to

[1] Medicalisation in its simplest form describes the process whereby bodies come to be objectified and medically classified, and previously unpathologised aspects of human life come to be constructed as medical conditions (Zola, 1972; Illich, 1982).

increased levels of adiposity. Using these terms signals positionality within the biomedical paradigm, and therefore, when I use these words, I use scare quotes to signal my positioning outside this paradigm. Some authors argue the term ‘fat’ conveys fewer value judgements than ‘obese’ or ‘overweight’ (e.g.Wiles, 1994). The term ‘fat’, historically used to insult larger people, has recently been politically reclaimed and used by fat activists as a neutral descriptor of the body (i.e. short/tall, thin/fat) as lesbian women and gay men reclaimed the term ‘queer’ and used it to signal self-acceptance (Wann, 2009). Although the word fat may have been appropriated to make social and political statements aimed at reducing the stigmatisation of larger people, progress is slow and there is still a good deal of stigma associated with its use. As there is no wide consensus on the use of this term it seems clear even cautious use is potentially problematic and context specific (Fikkan & Rothblum, 2012). Therefore when I use the term ‘fat’ I do so to more accurately represent the writing of other scholars in the field. At these times I use scare quotes only if they have been used in the original writing.

Feminist writer Carryer (2001) uses the term ‘embodied largeness’ in her work exploring women’s experiences of larger embodiment. The concept of embodied largeness was developed as part of Carryer's (2001) analysis which involved active involvement with her research participants. During this process she developed a good deal of insight and empathy about living with a larger body. Aside from Carryer's (2001) work the terms ‘large’ and ‘larger’ are not dealt with in literature discussing the use of terminology in relation to body size. However, several authors situated within the context of healthcare have used these terms in their work and this seems to be especially so in authors who particularly espouse body-acceptance and challenge weight-stigma (e.g. Brown & Thompson, 2007; Groth & Kearney, 2009; Teixeira & Budd, 2010).

Use of the term ‘larger’ is not addressed in the literature, perhaps as it also potentially denotes a deviation from a much-contested ‘norm’. However, in my discussions with my Research Advisory Group[2] (RAG) this term was much preferred

[2] I will discuss the involvement of the RAG in Section 4.4.1, and further information is also provided in Appendix 1.

by women and healthcare professionals self-identifying as ‘obese’, and this led me to cautiously use it in my early writing. As I write my thesis I now prefer the terms large or larger and Carryer's (2001) term ‘embodied largeness’. Perhaps because large is a word seldom used to discuss ‘fat people’ it seems to have the least negative connotations, and therefore feels more neutral than ‘overweight’, ‘obese’, or ‘fat’. I recognise the term lacks specificity and boundaries and therefore, for clarity’s sake, I use the term ‘larger’ to describe individuals who are medically classified as ‘obese’. I accept not all readers will necessarily agree with my use of language. However, I hope by making clear the thinking behind my language use I draw attention to my careful consideration in relation to avoiding the Othering of larger women.

1.2.1 Othering and stigma

Along with terms used to describe the body according to adiposity, I also use the terms Other and Othering in this thesis to describe the process whereby those who are *oppositionally* different from oneself are marked and named (Weis, 1995). My understanding of the process of Othering is influenced by DeBeauvoir's (2009) thinking on representation of Self and Other in which she stresses: "The category of the *Other* is as original as consciousness itself. The duality between Self and Other can be found in most primitive societies, in the most ancient mythologies” (italics original, p.6). Othering is associated with producing unequal power relations, reinforcing the domination and subordination of Other (Fine, 1994).

Elsewhere in the literature many authors prefer to talk about the marginalisation of larger people in terms of stigma. According to Link and Phelan (2001), stigma is the process whereby groups of individuals who possess a privileged characteristic (the ‘in-group’) brand those without this characteristic as belonging to the ‘out-group’. Once the out-group has been identified as different, the in-group mark as deviant the out-group by virtue of their shared characteristic. Stigma is therefore closely related to social power structures and relations. Although there are differences in the ways these processes are imagined and operationalized, both terms are used in relation to larger embodiment and I use both within the thesis. When I discuss ‘stigma’ I do so because I wish to stay close to the argument another author is making. At other times

I use the concept of Other and Othering as I feel doing so describes more closely the ways society tends to respond to larger embodiment.

1.2.2 Privacy and confidentiality

Throughout this thesis the names of the participants[3] and their family members, where mentioned, have been changed. Rather than assigning a name of my choosing I asked participants to choose a name themselves. I discuss fully the measures I took to maintain participants' privacy and confidentiality in Chapter 4.

1.3 Thesis layout

Thus far I have situated my positionality in relation to the study aims and described the purpose of the research. In this section I set out the layout of the thesis.

In chapter 2 I discuss the medical approach to 'maternal obesity' and provide an overview of the healthcare polices guiding the context of MHC. By critically examining the medical construction of the larger pregnant body I demonstrate that, although the medical position in relation to 'maternal obesity' constructs women's bodies in terms of failure, there are also contradictions and tensions with the biomedical problematisation of the larger pregnant body. Throughout the review I draw attention to aspects of the enactment of 'maternal obesity' policies, which relate specifically to MHP practice, and the construction of the problem of 'maternal obesity'. I also discuss the literature relating to research exploring MHP views about caring for larger women and contrast this writing with what is known about how larger women experience MHC. In doing so I draw attention to some particularly 'thorny issues', which potentially impact negatively on larger women's care, and require further theoretical exploration.

In Chapter 3 I draw on writing from the fields of sociology and anthropology of the body to argue that larger embodiment and the experience of pregnancy is best conceptualised and understood as a complex mixture of biology, culture and society (Lupton, 2012b). I problematise the socially constructed body and the biomedical

[3] Throughout the thesis when I refer to 'participants' I am referring to all the research participants i.e. the larger pregnant women, midwives, obstetricians and anaesthetists. When I discuss the pregnant women who took part in the study I refer to them as 'the women', or 'larger women'.

material body and I set out a means with which to 'think with the body' - theorising the body as social, cultural, political and lived (Scheper-Hughes & Lock, 1987; Jones, 2011). In doing so I bring together academic writing on gender and the governance of pregnancy, embodiment, medicalisation, risk and maternal blame as an approach to analysing and understanding embodied experiences of pregnancy in the context of the current medical, sociocultural and political milieu in which larger women experience their pregnancies and maternal care.

I begin Chapter 4 by situating my methodological approach within what has come to be known as 'narrative-based medicine', and which aims to explore the interwoven stories of patients and practitioners. I then move on to discuss my approach to studying human experience and sensemaking through the lens of social constructionism. I draw on Ricoeur's (1984, 1991) concept of 'narrative identity' and Gee's (1999) articulation of 'discourse', suggesting a conceptual framework for thinking about how we come to emplot and understand our experiences. I explain how studying larger women's and MHP stories of experience, provides an important means to investigate the way larger women's and MHP experiences are interwoven, revealing more about how the experience of MHC shapes pregnant embodiment.

In the second part of the chapter I explain the research design used in the study, exploring in detail the ethical issues relating to the study of larger embodiment and pregnancy. I also discuss the formation of the RAG who helped to sensitise me to important issues affecting larger embodiment. In this part of the chapter I describe the thinking behind the repeat interview design I utilised to investigate the experience of pregnancy, and the single interview design I used to explore how MHP understand larger embodiment as an aspect of their work. I also provide a detailed description of the ethical considerations relating to my interview design in regards to interviewing women during pregnancy. The chapter ends with a discussion about sample design, a description about how I approached recruiting participants and the considerations given to ethical issues relating to privacy, confidentiality and informed consent.

In Chapter 5 I describe the recruitment of participants to the study. I also draw on my field notes to demonstrate reflexive aspects of the research, detailing how critical

reflection shaped my engagement with participants during data collection. I discuss how I 'brought the body' into the data construction process and describe the challenges I found when faced with diverse forms of interview talk. I also discuss the context of the research interview as a dialogic performance (Riessman, 2008), describing how this configured my understanding of research interviews, and my approach to analysis. Relatedly, this part of the chapter describes my reflexive processes, discussing my relationship with the larger pregnant women and MHP who took part in the study and some of the challenges posed by my study design.

In part 2 of the chapter I describe the development of my approach to narrative analysis, discussing how I transcribed the interviews and the methods I utilised to attend to the dialogic context in which the data were generated. I also set out my method for identifying and analysing the stories contained within the data. I end the chapter setting out a rationale for my novel approach to presenting my research findings as a series of composite monologues.

Chapter 6 addresses a gap in what is known about larger women's pregnant embodiment and experience of MHC. The chapter is structured around 3 composite monologues illuminating women's experience of early pregnancy and early maternity care. These findings are interwoven with those from the interviews with community midwives who provide early pregnancy care. The chapter demonstrates how the women's tentative pregnancy experience was shaped by engagement with the context of MHC. The findings demonstrate larger women's early pregnancy experiences were far from straightforward, and involve high levels of emotion work in relation to fertility, pregnancy loss, and 'what a pregnant body can do'. These findings also illuminate the level of responsibility women felt in relation to protecting the foetus, also demonstrating they were somewhat dependent on medical technologies and medical expert knowledge over their own embodied knowledge.

In this chapter I also present findings demonstrating how larger women were highly visible targets for unsolicited MHP advice, and I reveal the assumptions midwives made about the women's lifestyles which I argue had the effect of rendering them invisible. Related to these findings are notions of 'targeting' and 'balance' which I found midwives drew on, depending on how they viewed larger embodiment. I also

illuminate the roles medical technologies and equipment play in practices involving the targeting of larger women in the context of MHC. This aspect of the analysis draws attention to how anti-obesity discourses of risk, blame and responsibility are operationalised when larger women's bodies are viewed as a barrier to the foetus, and conversely how the label of 'maternal obesity' is criticised by midwives. The findings I present in this chapter demonstrate that early pregnant embodiment, coupled with experience of early MHC, have a high degree of significance for larger women who may require additional emotional support and reassurance about their pregnancies.

In Chapter 7 I present and discuss findings relating to mid and late pregnancy. The chapter builds on those presented in Chapter 6, demonstrating how interaction with the wider maternity team in mid pregnancy, shapes women's pregnant embodiment as pregnancy progresses. The findings in this chapter are presented through 3 composite monologues of the women's experiences, and these are contextualised with findings drawn from interviews with midwives, anaesthetists and obstetricians. These findings focus on practices relating to monitoring foetal growth and antenatal anaesthetic consultations. As with Chapter 6, the findings presented in this chapter reveal how larger women represent highly visible targets for practices which appear disciplinary in nature. Central to the findings I present are those relating to the much-contested subject of gestational weight-gain (GWG), which I found dominated MHC consultations in mid and late pregnancy. In this respect, I also discuss findings which suggest practices of foetal growth monitoring and screening for gestational diabetes mellitus[4] (GDM), serve as a means to responsibilise larger women for foetal growth. These findings reveal how the intense focus on foetal size objectifies larger women, rendering the women further invisible as individuals, and stigmatising the foetus.

In Chapter 8 I address a gap in knowledge about larger women's experience of childbirth and the postnatal period. The chapter begins with an overview of the women's birthing experience, describing briefly the medical interventions the

[4] Gestational diabetes mellitus (GDM) is a form of diabetes associated with pregnancy. The condition normally spontaneously resolves following childbirth. Women who develop GDM are more likely to develop pre-eclampsia (a potentially serious complication of pregnancy) and the baby may grow larger than expected (Tieu *et al.*, 2014).

women experienced during childbirth. The composite monologues in this chapter draw on findings detailing 3 of the women's experiences of induction of labour, experiences in the labour ward and postnatal experience. These findings are woven with midwife and anaesthetists' experiences of managing larger women's labours. The findings demonstrate that, in contrast to the women's experiences, the much-feared worst-case scenario is foremost in MHP minds, configuring their practices in relation to the management of larger women's labours. The chapter also reveals differences in the midwifery framing of the larger birthing body, and those of obstetricians and anaesthetists. I also present findings which suggest the larger pregnant body is problematised by MHP in terms of providing a barrier to the foetus during childbirth. These findings shed further light on how the targeting of larger women acts in the context of the larger labouring body. I end this chapter with findings relating to women's postnatal experience, revealing that, once the foetus had been safely delivered, women felt somewhat abandoned. These findings demonstrate how MHP framings of the 'good' and the 'bad mother' bring sharply into focus the ways women are Othered in the context of MHC.

In Chapter 9 I discuss the main research findings and summarise the contributions made by this research. I also review the methodology used to answer the research questions, discussing the limitations of this approach, and make suggestions for future research. I end the chapter with reflection on the implications of this research in relation to ideas for public and professional engagement.

Chapter 2 The research context

2.1 Introduction

In this chapter I review the medical and healthcare literature relating to the larger pregnant body and the policies informing the care of larger women in Scotland. I also review research exploring larger women's experience of pregnancy care, and MHP views on providing care to larger women. The chapter aims to provide a context for the research by situating the study within broader medical and healthcare debates about larger bodies and the larger pregnant body.

I begin the chapter by briefly explicating the medical and public health position on the larger body with the aim of contextualising the medical management of 'maternal obesity' which I discuss in the next section. Having set out the medical approach to the larger pregnant body I then engage more critically with some of the themes within this literature and conclude this section by drawing attention away from the 'failings' of the larger body, suggesting the wider maternal care context, including the assumptions and expectations MHP have about the larger body, also shape larger women's pregnancy outcomes. In the following section I review healthcare literature examining the views of MHP in relation to their practice with larger women. This aspect of the review illuminates some of the 'thorny issues' these studies have highlighted. I then examine the findings from the small number of studies exploring larger women's experience of maternal care, also highlighting particularly problematic aspects of MHC which the women identify. In the final section of this chapter I set out the main points from the review, highlighting the need for more detailed critical and theoretical exploration of larger embodiment which accounts for the ways larger women's experience of pregnancy is shaped by MHC.

2.2 The medicalised larger body

The 'problem of obesity' has a fairly recent history with most people unfamiliar with the term prior to the 1990s. 'Obesity' scientists argue 'obesity' is a disease linked to

illnesses such as stroke, heart disease, type 2 diabetes[5], cancer and early death (Saguy & Almeling, 2008; Lupton, 2013a; Saguy, 2013). Due to the numbers of people who are now classified as 'obese', 'obesity' is now widely regarded as an epidemic and a significant threat to global health (WHO, 2000, 2002). With increased numbers of adults and children perceived to be at risk from 'obesity', government task forces, biomedical scientists, public health departments, health practitioners, and politicians have been mobilised to tackle 'obesity'. Moreover, the medical community suggest that, by avoiding becoming obese, individuals can reduce the risk of developing these conditions (WHO, 2018). In the medical context therefore, individuals whose BMI deviates from the 'healthy' range are most likely to be advised to seek measures to reduce their body size to within a medically acceptable BMI range.

2.3 The medicalised larger pregnant body

In conjunction with medical and public health concerns about larger bodies, interest in the larger pregnant body also began to emerge in the obstetric literature, and in 2010 the Centre for Maternal and Child Enquiries (CMACE) and the Royal College of Obstetricians and Gynaecologists (CMACE/RCOG) declared: "Obesity is arguably the biggest challenge facing maternity services today" (CMACE, 2010: p.xiii). The report was the culmination of a three year *Obesity in Pregnancy* project which was instigated due to concerns raised in the 2007 *Confidential Enquiry into Maternal and Child Health (CEMACH) Saving Mother's Lives* (Lewis, 2007).

The 2007 report highlighted a high number of maternal and infant deaths in which larger body size was implicated as a contributing factor. In addition to concerns about elevated risk of maternal mortality, the report also highlighted additional issues for 'obese' pregnant women and MHP including: increased risk of GDM; birth by caesarean section; and difficulties for practitioners in conducting procedures related to prenatal diagnosis, analgesia and anaesthesia. By the time CMACE published *Maternal Obesity in the UK: Findings from a National Project* (CMACE, 2010), the

[5] Type 2 diabetes is a condition related to high blood sugar and is believed to be associated with age, ethnicity and body mass. Treatment normally consists of oral medication and dietary interventions (NHS, 2017). The condition has become associated with obesity and high carbohydrate diets (NHS Choices, 2016a, 2016c).

subject of 'maternal obesity' was a prominent feature of medical, obstetric, and midwifery discourse, and had begun to capture the attention of the media who pointed out that women were putting their babies and themselves at risk by becoming pregnant while 'obese' (Blake, 2010).

2.4 Maternity care in Scotland: management of pregnancies, an overview

In Scotland the approach to NHS maternity care is guided by the overarching *Refreshed Framework for Maternity Services in Scotland* (Scottish Government, 2011). The policy is implemented through the NHS Healthcare Improvement Scotland (NHS HIS) *Keeping Childbirth Natural and Dynamic* (KCND) programme (NHS HIS, 2009). KCND emphasises evidence based individualised care and covers the antenatal, labour, and postnatal care of mother and baby. All records made about the pregnancy are made in the *Scottish Women Hand Held Maternity Record* (SWHMR) (NHS HIS, 2011) which women take to all their MHC consultations. KCND also promotes a multi-professional approach to the provision of care including, but not limited to, midwives, obstetricians, anaesthetists, general practitioners, public health nurses, dieticians, and so on.

The practice guidance for professionals supporting the delivery of these policies is articulated through the NHS Quality Improvement Scotland (NHS QIS) *Pathways for Maternity Care* (NHS QIS, 2009). This document details the care pathways recommended for pregnant women according to their risk status. Central to the ideology of this approach is the view of pregnancy as a normal physiological process whereby intervention should be kept to a minimum, keeping maternity care closer to a social, or midwifery model, rather than a medical model of care (van Teijlingen, 2005).

Following the main policy guidance *Pathways for Maternity Care* (NHS QIS, 2009), each pregnancy is awarded a status: green, amber, or red. In low-risk pregnancies, pregnancy care follows the green pathway, and the lead professional is the midwife (midwife-led care). Low-risk pregnancies include women with 'uncomplicated' pregnancies who are defined as healthy, women between 16 and 40 years old, and

women with a BMI between 18 and 34.9kg/m^2. Women identified as requiring further assessment (amber pathway) are referred to appropriate members of the maternity care team. Depending on the outcomes of the assessment, women may be returned to the green pathway and the pregnancy managed by the community midwife. Meanwhile, pregnancies whereby the wellbeing of the mother and/or foetus[6] may be compromised are categorised as high-risk (red pathway). These pregnancies are termed 'obstetric-led care' and also involve the wider maternity care team. 'High-risk' pregnancies include women with 'significant health problems' and women with BMI ≥35kg/m^2. Women on the red pathway continue to see the midwife in the community setting. However, they will also attend the antenatal clinic at the maternity hospital for consultations with the obstetrician and/or other health professionals for further assessments and/or interventions.

Antenatal healthcare is conducted at home, at the GP surgery/health centre, or at the local maternity hospital. The first contact with the midwife is known as the 'booking appointment', and focuses on gathering information, conducting risk assessments, providing advice, making arrangements for follow-up appointments, and discussing the options for antenatal care and preferences for childbirth. In all pregnancies screening and monitoring take place at specific junctures of the pregnancy. Screening involves a variety of blood and urine tests along with ultrasound scans. Routine monitoring includes abdominal palpation to detect fundal height[7]. Ultrasound is used to determine the gestational age of the foetus (dating scan), to detect Down's Syndrome (nuchal translucency scan), and to detect problems with the foetus (foetal anomaly scan).

As in the rest of the UK, women giving birth in Scotland with pregnancies medically defined as uncomplicated, are encouraged to choose the place where they give birth i.e. home, freestanding midwifery unit, alongside midwifery unit (AMU) (in close proximity to the obstetric unit), or obstetric unit (OU). Women with 'high-risk'

[6] Rather than using the technical spelling of 'fetus' I use the non-technical British spelling which is foetus (Oxford Dictionary, 2018).
[7] Fundal height is used to calculate foetal growth during pregnancy and is measured by calculating the distance between the pubic bone and the top of the uterus (Robert *et al.*, 2015).

pregnancies are strongly advised to give birth in the OU of their local maternity hospital (Scottish Government, 2011).

2.5 The creation of medical knowledge about 'maternal obesity'

In this section I examine some of the medical evidence informing the maternal care guidelines discussed in the last part of this chapter.

Mulherin *et al.* (2013: p.2) argue biomedical interest in the large pregnant body can be described as "burgeoning" making a full review neither possible nor practical. In this section of the chapter I review literature which is typical of studies on which the current maternal care policies are based. These studies comprise of UK based empirical studies (e.g. Sebire *et al.*, 2001; Bhattacharya *et al.*, 2007), International studies (e.g. Barau *et al.*, 2006; Ovesen, Rasmussen & Kesmodel, 2011), review articles (e.g. Yu, Teoh & Robinson, 2006; Mafort *et al.*, 2016), and special reports (e.g. Catalano, 2010) published primarily within peer-reviewed medical journals. This research takes a quantitative approach to studying maternal and/or infant health outcomes and pregnancy complications in women who are medically classified as 'obese'. Such research often involves large study populations of between several thousand and several hundred thousand women. The methodologies used in this type of research includes case controlled studies (e.g. Lashen, Fear & Sturdee, 2004), retrospective cohort studies (e.g. Sebire *et al.*, 2001; Bhattacharya *et al.*, 2007), population-based prospective cohort studies (e.g. Gaillard *et al.*, 2011), and observational studies (e.g. Barau *et al.*, 2006). This type of empirical evidence represents the 'gold standard' of evidence-based medicine (Timmermans & Berg, 2003), forming the basis of biomedical maternal obesity discourse, providing the context for: care guidelines; practitioner practices; screening; monitoring; and medical interventions. I have already hinted at the powerful nature of medical discourse in relation to 'maternal obesity' and I will revisit this aspect of my research in Chapter 3, when I examine risk discourse and the governance of pregnancy in more detail.

Meanwhile, this section is structured according to the themes contained in the obstetrical and biomedical literature with the aim of examining how the large pregnant body is problematised. Each theme reveals how larger women's bodies are framed as risky and faulty, thereby focusing on the failings of the large female body.

2.5.1 Medical problems

Medical research evidence suggests 'maternal obesity' potentially leads to various maternal complications including increased risk of miscarriage (Lashen, Fear & Sturdee, 2004). Furthermore, it is claimed larger body size may impact negatively on various physiological mechanisms during pregnancy, for example, respiratory functioning (Mafort *et al.*, 2016) and insulin sensitivity (Catalano, 2010). Therefore, according to these findings, larger women may experience exacerbation of respiratory problems such as asthma, and metabolic conditions such as GDM during pregnancy (CMACE/RCOG, 2010).

Some studies report medical complications relating to blood clotting and excess bleeding may be associated with the larger pregnant body, with higher BMI women experiencing problems with thromboembolism[8] (Larsen *et al.*, 2007; Jacobsen, Skjeldestad & Sandset, 2008), postpartum haemorrhage[9] (Sebire *et al.*, 2001; Bhattacharya *et al.*, 2007) and a higher risk of wound infection (Sebire *et al.*, 2001). Although rarely addressed in the medical literature, it is also important to note that problems with thromboembolism, haemorrhage, and wound infections, are also associated with medical interventions in pregnancy, for example, caesarean delivery (Knight *et al.*, 2008).

Other medical problems, which are reported to occur more often in larger women, include conditions specifically associated with pregnancy affecting both mother and foetus. These include pre-eclampsia[10] (Sebire *et al.*, 2001; Yu, Teoh & Robinson, 2006; Bhattacharya *et al.*, 2007; Ovesen, Rasmussen & Kesmodel, 2011), gestational

[8] Thromboembolism is associated with serious complications such as deep vein thrombosis and pulmonary embolism (a potentially fatal condition) (RCOG, 2018).
[9] Postpartum haemorrhage is heavy bleeding (often from the area where the placenta was attached) after the birth of the baby (RCOG, 2018).
[10] Pre-eclampsia (also known as toxaemia) is a condition occurring in the second half of pregnancy. In severe pre-eclampsia the baby is delivered early (RCOG, 2018).

hypertension[11] (Bhattacharya *et al.*, 2007; Gaillard *et al.*, 2011) and GDM (Sebire *et al.*, 2001; Ovesen, Rasmussen & Kesmodel, 2011). The risks of these conditions are believed to increase in relation to BMI, therefore, women with very high BMIs are viewed as having more complex needs than women with lower BMIs.

2.6 Medical guidelines for managing 'maternal obesity'

In pregnancy women with a BMI ≥30 kg/m^2 at the first antenatal appointment are classified as having 'maternal obesity' (CMACE/RCOG, 2010), and the medical care they receive is based on the CMACE/RCOG *Joint Guideline: Management of Women with Obesity in Pregnancy* (CMACE/RCOG, 2010). Although the *Joint Guideline* pertains to the care of all women with 'maternal obesity' (i.e. with a BMI ≥30kg/m^2), some of the recommendations relate specifically to women with higher classes of BMI. The guideline advises local maternity services to consider: "the balance of medical intervention versus risk, differences in local prevalence of maternal obesity, and resource implications" (p.2). Therefore, the implementation of the guidelines reflects some local policy variations with regard to cut-off points for screening and restrictions (i.e. access to midwife-led units) in relation to the care of women with 'maternal obesity'.

Pathways for Maternity Care (NHS QIS, 2009) recommends all women with BMI ≥35kg/m^2 are referred to the maternity team for assessment and considers women with lower BMIs to be of lower risk. The CMACE/RCOG (2010) *Joint Guideline* provides an outline for the nature of discussions which should take place with women. Primarily the aim is to inform larger women of the risks associated with their pregnancy, and the forms of intervention which may be required to reduce these risks:

> [I]ncreased risk of pre-eclampsia, gestational diabetes and fetal [sic] macrosomia requiring an increased level of maternal and fetal monitoring; the potential for poor ultrasound visualisation of the baby and consequent difficulties in fetal surveillance and screening for anomalies; the potential for difficulty with intrapartum fetal monitoring, anaesthesia and caesarean section which would require senior obstetric and anaesthetic involvement and an antenatal

[11] Gestational hypertension is raised blood pressure during pregnancy (RCOG, 2018).

> anaesthetic assessment; and the need to prioritise the safety of the mother at all times. Women should be made aware of the importance of healthy eating and appropriate exercise during pregnancy in order to prevent excessive weight gain and gestational diabetes. Dietetic advice by an appropriately trained professional should be provided early in the pregnancy (CMACE/RCOG, 2010).

This lengthy list of potential complications, and associated screening and monitoring, forms the basis for the discussions with women in consultations with MHP. It is important to note this guidance also reflects a reductionist understanding of embodied largeness: making assumptions about larger women's diets and exercise status. Such framing reflects the medical model approach to care (van Teijlingen, 2005). A reductionist approach is also reflected in the blanket labelling of all larger women as 'high-risk'. For example, following the pathway approach (NHS QIS, 2009) and the recommendations from the CMACE-RCOG (2010) *Joint Guideline*, women with a BMI ≥35kg/m^2 are considered to be "women with significant medical/obstetric risk factors" (p.8) and, despite the absence of health issues which may impact on the pregnancy, the pregnancy is labelled 'high-risk'[12].

Women with a BMI ≥35kg/m^2 are therefore routinely referred to the obstetric team for further assessment regardless of their health status or parity[13]. The typical care package for women with a BMI ≥35kg/m^2 includes: a booking assessment with the community midwife, referral to the maternity care team for a medical assessment/follow-up medical assessments; additional ultrasound scans to monitor foetal growth; and an oral glucose tolerance test[14] (OGTT) for GDM (CMACE/RCOG, 2010; NICE, 2016a). Women with a BMI ≥40kg/m^2 are also routinely referred for an anaesthetic assessment. The purpose of the assessment is to identify any potential problems with gaining medical access to the women's airway, spine and veins should she need a general or regional anaesthetic. The anaesthetist

[12] Health issues which are normally considered to increase the risk of complications during pregnancy include: previous pre-eclampsia; stillbirth or neonatal death; serious co-existing medical conditions such as heart conditions and malignancies; severe mental health conditions; and drug and alcohol problems (NHS QIS, 2009).
[13] Parity describes the number of times a woman has given birth to a foetus ≥24 weeks gestation (Tiran, 2017).
[14] An oral glucose tolerance test is used to diagnose diabetes in pregnancy. The test involves measuring the level of glucose in the blood after fasting.

also discusses the risks associated with general and regional anaesthetic and discusses early intervention verses emergency procedures as: “an early epidural may be advisable” (CMACE/RCOG, 2010: p.7).

2.6.1 Progression of labour

Larger women are reported to have poorer uterine contractility (poorer contractions during labour) than their lower weight counterparts, which means labour may last longer (Vahratian *et al.*, 2004; Barau *et al.*, 2006; Bergholt *et al.*, 2007; Homer *et al.*, 2011). Additionally, larger women are also reported to experience an increased incidence of labours termed as failing to progress (where labour slows down or stops) (Sheiner *et al.*, 2004; Heslehurst *et al.*, 2008). It has been proposed the reason for a labour which fails to progress is that the passage of the baby is hampered by fatty tissue in the vagina (Crane *et al.*, 1997). However, these claims have been unsupported by medical imaging (Veerareddy, Khalil & O’Brien, 2009). When labour is slow larger women are at higher risk of various clinical interventions including augmentation of labour (giving medication to strengthen contractions) instrumental delivery[15] and intrapartum[16] caesarean deliveries (Zhang *et al.*, 2007; Cedergren, 2009; Kominiarek *et al.*, 2011).

2.6.2 Longer and shorter pregnancies

Some studies have demonstrated larger women may experience shorter gestational periods. Therefore, they are believed to have an increased risk of pre-term delivery[17] (Bhattacharya *et al.*, 2007). Conversely, longer gestational periods are also reported as being particularly problematic (Usha Kiran *et al.*, 2005; Smith *et al.*, 2007; Denison *et al.*, 2008). Consequently, some of the risks reported in the literature specifically relate to medical interventions which are conducted for prolonged gestation. This includes an increased risk of induction of labour (Sebire *et al.*, 2001; Usha Kiran *et al.*, 2005; Bhattacharya *et al.*, 2007; Hildingsson & Thomas, 2012). Moreover, some studies suggest larger women are twice as likely to experience induction of labour or caesarean section (Usha Kiran *et al.*, 2005; Cedergren, 2009).

[15] An instrumental delivery refers to the use of forceps to help deliver the baby during the pushing part of labour (RCOG, 2018).
[16] Intrapartum means ‘during birth’ (RCOG, 2018).
[17] Pre-term refers to a delivery before 37 week gestation (RCOG, 2018).

Furthermore, as BMI increases so does the risk of interventions such as induction of labour (Bhattacharya *et al.*, 2007).

An induced labour may also lead to emergency caesarean section, and more larger women who are induced also experience more emergency caesarean sections compared to lower weight women (Sebire *et al.*, 2001; Bhattacharya *et al.*, 2007; Arrowsmith, Wray & Quen, 2011; Ovesen, Rasmussen & Kesmodel, 2011; Hildingsson & Thomas, 2012). A higher rate of instrumental delivery is also reported in larger women (Yu, Teoh & Robinson, 2006), and increased risk of planned caesarean section (Ovesen, Rasmussen & Kesmodel, 2011). Both of these interventions are more common for larger women expecting their first baby (Smith *et al.*, 2007). Larger women are also reported to experience more anaesthetic complications making epidural, spinal and general anaesthetics more complex should an emergency caesarean section be required following a failed induction of labour (Dresner, Brocklesby & Bamber, 2006).

2.6.3 'Fat babies'

Along with maternal size, the size of babies born to larger women has also captured medical interest, and studies suggest larger women are more likely to give birth to babies described as macrosomic[18] or large-for-gestational-age[19] (LGA) (Usha Kiran *et al.*, 2005; Yu, Teoh & Robinson, 2006; Bhattacharya *et al.*, 2007; Ovesen, Rasmussen & Kesmodel, 2011). Scottish statistics suggest there has been a gradual increase in babies weighing ≥4000g, going from 8% in the 1970s to 13% in 2016-17 (ISD Scotland, 2017). LGA babies are reported to be especially associated with GDM (Heude *et al.*, 2012) and/or increased or 'excessive' weight-gain (Heude *et al.*, 2012; Warin *et al.*, 2012). However, the association of 'maternal obesity' and LGA babies is hotly contested (Robinson *et al.*, 2003).

Other research also suggests LGA babies may have a propensity to develop metabolic syndrome[20] leading to 'obesity' in later life (Boney *et al.*, 2005). LGA

[18] Macrosomia describes babies who have a birth weight ≥4000g (Boulvain *et al.*, 2016).
[19] Large-for-gestational-age refers to foetuses above the 90th percentile for gestational age (Hoff *et al.*, 2009).
[20] Metabolic syndrome is a condition whereby problems metabolising sugar and fat leads to the medical condition of 'obesity' (Boulvain *et al.*, 2016).

babies are also reported to be associated with a variety of problems relating to maternal and infant injury (Ju, Chadha & Donovan, 2009), are implicated in longer labours, and associated with an increased risk of caesarean delivery (Boulet *et al.*, 2003). LGA babies are also believed to be associated with a higher risk of shoulder dystocia[21], which is a very rare birth complication (Robinson *et al.*, 2003; Boney *et al.*, 2005), but nonetheless, presents a high level of concern among MHP due to the emergency situation this complication creates (e.g. Richens, 2008; Irwin, 2010).

2.6.4 Stillbirth, preterm delivery and congenital problems

Some medical research suggests larger women's babies are at risk from stillbirth, and that neonatal death, and the risk of stillbirth may be twice that of women with 'healthy' BMIs (Cedergren, 2004; Kristensen *et al.*, 2005; Yu, Teoh & Robinson, 2006). Although the causes are not well established, some studies suggest blood pressure and blood sugar disorders such as GDM may play a part in stillbirth (Chu *et al.*, 2007a). The risk of preterm birth and delivering a small-for-gestational-age (SGA) baby is also higher, and smaller size infants have been shown to experience various complications associated with poorer infant outcomes (Sebire *et al.*, 2001; Abenheim *et al.*, 2007; Smith *et al.*, 2007; Ornoy, 2011).

As diets rich in high glycaemic-index (GI) foodstuffs (i.e. sugary foods) are reported to be associated with neural tube defects (NTD)[22] (Sarwer *et al.*, 2006), studies have also been conducted exploring whether larger women are more likely to conceive a child with this form of congenital impairment. The hypothesis is that risk of NTD increases along with maternal size (Rasmussen *et al.*, 2008). It appears this hypothesis is based on the assumption that larger women consume a diet rich in sugary foods, whereas in reality, the cause is unknown (e.g. Yazdy *et al.*, 2010).

Researchers have also sought to establish whether the long term health of babies born to larger women have an increased risk of developing heart disease (Barker, 2000) and type 2 diabetes (Dabelea *et al.*, 2000). Studies such as these draw on Barker's

[21] Shoulder dystocia describes a rare emergency situation whereby the baby's head is born but one of the shoulders becomes stuck behind the mother's pubic bone. It requires swift medical response (RCOG, 2018).
[22] Neural tube defects relate to problems with the brain, spine and spinal cord, i.e. spina bifida (NICE, 2016b).

(2004) hypothesis (also known as Developmental Origins of Health and Disease Theory). Barker's hypothesis represents what Warin *et al.* (2012) term a 'paradigmatic development' in biomedical research. Barker's theory supports the idea that foetal metabolism and physiology are permanently altered by the uterine environment, leading to health conditions such as heart disease, type 2 diabetes and obesity (Oken & Gillman, 2003; Whitaker, 2004).

2.7 Failed 'fat bodies' or gaps in knowledge?

In reviewing literature which is critical of the medical framing of the larger pregnant body, I found two main arguments. Firstly, authors identify inconsistencies within the medical literature, indicating the large pregnant body is less medically problematic than previously believed. Secondly, I found that authors tended to identify iatrogenic[23] factors as contributing to the complications experienced by larger women. In the remainder of this part of the chapter I discuss both of these arguments.

2.7.1 Contradictory findings

Despite the intensity of evidence suggesting maternal obesity is associated with poor pregnancy outcomes, as one might expect, some studies also report contradictory evidence (Hollowell *et al.*, 2013). Heslehurst *et al.* (2008) reviewed the pregnancy outcomes of 17,230 women with no medical or obstetric risk factors other than 'obesity'. Although the study reported an increased risk of instrumental delivery, caesarean section, maternal haemorrhage, maternal infection and infants requiring intensive care, they also found that, in multiparous[24] women without coexisting health problems, there were lower intrapartum risks than were previously believed. Importantly, these results also strongly suggest larger women are at an increased risk of complications from the medical interventions associated with obstetric-led care.

Similarly, Ovesen, Rasmussen and Kesmodel (2011) also found a lack of significant statistical evidence suggesting an increased risk of haemorrhage and thrombosis in

[23] Iatrogenic describes illness caused by medical examination or treatment (I discuss this in more depth in Chapter 3) (Illich, 1976).
[24] Multiparity describes a woman who has given birth to more than one child (Tiran, 2017).

larger women, as do Heslehurst *et al.* (2008). Furthermore, Bhattacharya *et al.* (2007) suggest the reported incidence of blood loss following delivery could in part be explained by an increase in the interventions larger women experience (rather than larger bodies being predisposed to bleed). Bhattacharya *et al.* (2007) also note the measurement of maternal blood loss is subjective, which thereby raises important questions about how the larger body is viewed and evaluated by MHP.

2.7.2 Iatrogenic factors

According to Hollowell *et al.* (2013), the CMACE/RCOG (2010) *Joint Guideline* recommendation that all larger women give birth in OUs is based on consensus rather than actual empirical evidence. In this respect, Misra, Guyer and Allston (2003) and Iessa and Bérard (2015) further suggest the blanket labelling of healthy high BMI women as 'high-risk' is highly problematic in that this approach fails to acknowledge important factors, which also determine pregnancy outcomes. These include: current health; previous pregnancy outcomes; age; economic and social status and environmental factors. These authors concur with others who argue larger women's pregnancies may be unnecessarily medicalised. Therefore, the poor outcomes experienced by some larger women may be strongly influenced by iatrogenic factors, rather than excess body fat (e.g. DeJoy & Bittner, 2015). For this reason, Hollowell *et al.* (2013) argue the risks women face in relation to delivering in OUs may increase the complications experienced by larger women and should, therefore, be considered as an independent risk factor among other risk factors.

2.7.3 Caesarean deliveries

One of the complications frequently referred to in the CMACE/RCOG (2010) *Joint Guideline* is caesarean section. As I have already discussed earlier in this section, evidence arising from biomedical research suggests a straightforward association between BMI and risk of caesarean delivery. Women labelled as 'obese' are viewed as being more than twice as likely to experience induction of labour, leading to an emergency caesarean section, than their lower-weight counterparts (e.g. Sebire *et al.* (2001). Therefore, caesarean section represents a significant concern in relation to the maternal care of larger women.

Currently, factors associated with 'obesity', such as suspected macrosomia and increased induction rates are generally accepted as the most common reasons why more women undergo caesarean sections. However, the mechanisms leading to this are very unclear, and some authors suggest more research is needed which specifically explores the reasons why so many caesarean sections are conducted on larger women (Chu *et al.*, 2007b; DeJoy & Bittner, 2015). In this respect studies have found that, rather than BMI affecting caesarean section rates, the management of women in labour has a far greater effect. These findings suggest wider influences on the high rates of caesarean sections than are currently recognised (Abenhaim & Benjamin, 2011).

Two aspects relating to clinical decision-making are prominent in the critical literature: 'failure to wait' and expectations about the size of larger women's babies. Failure to wait is implicated when caesarean sections are conducted when labour is slow to progress. With a large number of studies suggesting 'maternal obesity' is associated with poor uterine contractility (e.g. Norman *et al.*, 2012; Bogaerts *et al.*, 2013; Carlhall, Kallen & Blomberg, 2013), larger women's labours have been identified as having the potential to be more protracted than their slimmer counterparts (although this is not always the case) (Heslehurst *et al.*, 2008). Therefore, authors critical of the intrapartum management of 'maternal obesity' suggest that failure to wait during the first stage of labour may account for the higher numbers of larger women experiencing caesarean births (Vahratian *et al.*, 2004; Abenhaim & Benjamin, 2011). These findings divert attention away from the 'failings' of the larger body: implicating the medical management of these pregnancies.

Larger babies are also implicated in the high numbers of caesarean sections associated with 'maternal obesity'. Whether larger women have LGA babies is a hotly contested area of literature (Robinson *et al.*, 2003). Literature in this area reflects MHP fear relating to shoulder dystocia, which medical literature suggests is particularly associated with larger women who are expected to have LGA babies (Hull *et al.*, 2011). However, recent research suggests shoulder dystocia may not be distinctly associated with larger women's pregnancies (Wispelwey & Sheiner, 2013).

In this respect, DeJoy and Bittner (2015) argue that, weight-stigma is at the root of the high levels of surgical and medical interventions involved in larger women's pregnancies. This argument is based on the suggestion that women may be advised to undergo caesarean deliveries due to the *expectation* one will be required. If this is the case, some of the complications larger women face relate to the medicalisation of their pregnancy, rather than their BMI. For this reason DeJoy and Bittner (2015) argue larger women may face discrimination in maternity settings due to weight-stigma, which is based on the assumptions made about the capacities and limitations of their bodies.

2.7.4 Big babies

As I set out in Section 2.6.4, research suggests larger women are more likely to have LGA babies than their slimmer counterparts (Usha Kiran *et al.*, 2005; Yu, Teoh & Robinson, 2006; Bhattacharya *et al.*, 2007; Ovesen, Rasmussen & Kesmodel, 2011). However some studies report that larger women, who are otherwise healthy (i.e. those without metabolic conditions such as type 1 diabetes mellitus[25] or GDM), are no more likely to produce LGA babies than their slimmer counterparts (e.g. Robinson *et al.*, 2003).

I found the literature examining the relationship between LGA babies, larger women's pregnancies, and clinical interventions to be quite a contentious area as it revealed some of the contradictions regarding the assumptions made about the larger pregnant body. For example, a recent systematic review and meta-analysis suggests that 3.9% of larger women give birth to LGA babies. This figure contrasts with 1.6% of LGA babies which are born to 'underweight' or 'normal-weight' mothers (Gaudet *et al.*, 2014). This suggests that although larger women are more likely to have LGA babies (compared with women with lower BMIs), the numbers are still small. Furthermore, literature also suggests estimates of foetal size may be inaccurate. The main examinations used to estimate foetal weight and growth are ultrasound techniques, maternal abdomen measurements (symphysis-fundal height), and use of

[25] Type 1 diabetes is a lifelong condition where the body fails to produce enough insulin and insulin injections are required to lower blood sugar (NHS, 2018).

foetal weight calculators[26] which are prone to the influence of individual subjectivity (Phillips *et al.*, 2014). Some research suggests LGA babies are very difficult to detect prior to birth (Chauhan *et al.*, 2005; Coomarasamy *et al.*, 2005; Iffy *et al.*, 2007; Sadeh-Mestechkin *et al.*, 2008). One study suggests that, at best, only a third of babies who are classified as LGA were detected using ultrasound techniques during the two weeks prior to birth (Phillips *et al.*, 2014). Taking maternal measurements has also been shown to produce similar inaccuracies (Robert *et al.*, 2015). Despite the problems in detecting LGA babies using these methods, they are routinely used to guide clinical decision making including the decision to induce labour early in pregnancies where LGA babies are suspected (Boulvain *et al.*, 2016).

In the context of the wider 'obesity epidemic' one of the responses to concerns about LGA babies has been to focus on limiting maternal weight-gain in women who are perceived as at risk of gaining too much weight. Typically these interventions target women with metabolic disorders such as GDM, type 1 diabetes, and women who have already delivered a large infant. In a systematic review of interventions designed to reduce macrosomia, Catalano and DeMouzon (2015) found these types of interventions were not successful in reducing foetal growth. Furthermore, they suggest that complicated biological and genetic mechanisms which are outwith women's control are more likely to be responsible for LGA (Catalano & DeMouzon, 2015).

2.7.5 Are larger mothers creating the next generation's problems?

More recently, interest has grown in the long-term health of babies born to larger women, with suggestions that these babies may also have increased risk of health conditions such as autism (Reynolds *et al.*, 2014), asthma (Forno *et al.*, 2014), metabolic disorders (Boney *et al.*, 2005), developmental problems such as ADHD (Chen *et al.*, 2014), poor psychosocial development (Jo *et al.*, 2015), and physical developmental delay (Wylie *et al.*, 2015). The quality and significance of the research reported in these studies varies, and some of it has been openly contested by

[26] Foetal weight calculators use various measurements to estimate the size of the baby including growth charts (Tiran, 2017).

other authors, for example, Langley and Thapar's (2014) reply to Chen *et al.* (2014). Meanwhile, Iessa and Bérard's (2015) systematic review of the evidence supporting an association between maternal body weight and foetal congenital abnormalities also suggests there are a number of issues and gaps in knowledge in relation to the research in this area.

It is worrying to note that even personal characteristics such as intelligence quotient (IQ) have captured the interest of researchers working in this field (e.g. Kristensen *et al.*, 2014). Research in this area includes Wylie *et al.'s* (2015) comparison of infant physical development which alludes to an association between physical development and cognitive abilities. The consequence of such framing may have longer-term implications for the children of larger women. The motivation for conducting research such as this is unclear, but this type of research has a historical context, which may have relevance in understanding the motivations of these researchers.

Research examining the association of physical human features and characteristics, such as IQ, has a historical basis and is rooted in what is termed the 'golden era of classification'. According to Gould, (1980, cited by Oliver, 2006), this era saw scientists measuring bodily features and attempting to make predictions about human traits or characteristics which would support the claims of powerful elite groups[27]. One of the outcomes of this work served to justify the continued discrimination of less powerful societal groups (Gould, 1980, cited by Oliver, 2006). In reviewing the medical research on the large pregnant body, it does appear some of this is a conscious effort to establish links between excess fatness and various negative human characteristics, and as such, this may serve to perpetuate the Othering of the large body.

Barker's (2004) hypothesis, which I drew attention to in Section 2.7.5, appears to be a modern twist on the golden era of classification. Although Barker's hypothesis remains controversial, the theory has now found some support particularly in relation to the effect of maternal diet and future children (Moore & Davies, 2005; Warin *et*

[27] One example of this is the supposed connection between IQ and race; people with small foreheads were believed to be 'ape-like' and this characteristic was supposedly linked to criminality (Oliver, 2006).

al., 2011). However, Warin *et al.* (2012) suggest that, although the bioscientific community urge caution in relation to the notion that maternal diet during pregnancy programmes the foetus for future 'obesity', the media have nonetheless been very enthusiastic in reporting that larger women are more than twice as likely to have macrosomic babies who become 'obese' adults. Warin *et al.* (2011, 2012) therefore, argue Barker's hypothesis has had far reaching effects, intensifying the focus of medicine on pregnant women's lifestyles and increasing the Othering of larger women through 'mother blame'. Warin *et al.'s* (2011, 2012) work adds to an important body of feminist and critical literature exploring the ways larger mothers are increasingly blamed for the origins of adult health in the context of gender and social inequality (e.g. Keenan & Stapleton, 2010; McNaughton, 2011; Lupton, 2012a, 2012b). This literature has great significance in relation to understanding the ways medicine and society respond to the larger pregnant body and I examine this in greater detail in Chapter 3.

2.8 MHP views on the care of larger women

2.8.1 Introduction

In the next part of this chapter I review the literature relating to current knowledge about MHP experience of caring for larger pregnant women. The review thus takes a paradigm shift, moving to qualitative findings about the context of maternal healthcare. The purpose of this section is to explore in more detail what is already known about MHP practice in relation to larger women's care. I begin this part of the chapter by contextualizing existing research, explaining the type of research which has been conducted, before going on to set out the somewhat 'thorny issues' the research I review has drawn attention to. By doing so I shed light on how the policies relating to the management of larger women's pregnancies are acted out in the context of MHC.

2.8.2 The creation of knowledge about MHP views

Concerns about adequate care provision for larger women has led a number of qualitative researchers to explore MHP views, attitudes and experiences of providing care to larger women (e.g. Furness *et al.*, 2011; Heslehurst *et al.*, 2011; Schmied *et al.*, 2011; Smith, Cooke & Lavender, 2012; Heslehurst *et al.*, 2013; Knight-Agarwal

et al., 2014; Singleton & Furber, 2014). These studies primarily draw on data from interviews and focus groups. Some of this research takes a phenomenological approach (e.g. Singleton & Furber, 2014; Knight-Agarwal *et al.*, 2014), while others take a qualitative descriptive approach (e.g. Furness *et al.*, 2011; Heslehurst *et al.*, 2011; Schmied *et al.*, 2011; Smith, Cooke & Lavender, 2012; Heslehurst *et al.*, 2013). Although some of this research aims to explore MHP views and attitudes toward their work with larger women (e.g. Knight-Agarwal *et al.*, 2014), the majority of these studies focus on either exploring how practitioners feel services should be developed, how effective established services are (e.g. Heslehurst *et al.*, 2011; Smith, Cooke & Lavender, 2012), or are aimed at identifying the training and educational needs of MHP (primarily midwives) (Heslehurst *et al.*, 2013).

Although the majority of this research involves only midwives, some studies state they aimed to involve MHP from the wider MHC team including obstetricians and anaesthetists. Some studies are however not clear about who took part (e.g. Smith Cooke & Lavender, 2012). Knight-Agarwal *et al.* (2014) involve obstetricians, and Schmied *et al.* (2011) include an anaesthetist and two obstetricians. Therefore, key health professionals, such as obstetricians and anaesthetists are somewhat under-represented in the research discussed in this section.

Taking a slightly different approach, Furness *et al.* (2011) juxtapose the experience of larger pregnant women and MHP by involving both larger women and midwives in separate focus groups, examining the effectiveness of an intervention designed to support larger pregnant women. Designing the study in such a way enabled the researchers to identify where the data converged and contrasted. Although these studies may lack a theoretical framework, nonetheless, they offer a glimpse of the issues concerning MHP in the context of larger women's maternity care. Only Schmied *et al.* (2011) and Singleton and Furber (2014) aim to more fully explore the concerns and issues raised by practitioners. Schmied *et al.*'s (2011) study drew on a large data set of 37 MHP in three separate maternity units, providing a detailed and interesting descriptive analysis of MHP views about their work. However, both these studies do not move beyond description, suggesting further research is required to

develop a more nuanced understanding of the context in which larger women receive their care.

2.8.3 What have MHP said about caring for larger women?

My review of the findings from these studies reveals several issues which can be described as 'thorny issues': these are rarely straightforward and present a number of contradictions. Here I discuss these issues with the aim of pinpointing some of the more challenging areas which are more fully explored through theoretical lenses in Chapter 3.

2.8.4 Thorny issue 1: talking about body size and weight-related issues

Two studies exploring the maternity provision for larger women (Heslehurst *et al.*, 2011) and the training needs of midwives (Heslehurst *et al.*, 2013) provide an interesting snapshot of some of the issues which midwives have raised about caring for larger women. In the earlier study Heslehurst *et al.* (2011: p.e172) had found that midwives were framing their work with larger women in the following way, asking:

> What else can we do other than see them more regularly, ask them "are you eating well and have you changed your diet, have you done a bit more exercise?"

This quote highlights how midwives understand their practices with larger women in terms of the surveillance of lifestyle issues such as eating and exercise. In response to the concerns raised by midwives Heslehurst *et al.* (2013) involved midwives in further research examining their views about their training needs in relation to caring for larger women. Although the research was aimed at identifying specific training needs, the findings also reveal midwives have expectations about the relationship between providing women with information and behaviour change. For example, the midwives in the study describe their frustration when they provide specific advice regarding healthy eating to women, but the women fail to follow this advice.

Although midwives may see the practice of 'information-giving' as an important aspect of their role in antenatal care, research has established that midwives are very conscious about issues which may affect the development of a trusting relationship

with the women they care for, and have said they often feel reluctant to raise the issue of 'maternal obesity' with women due to fears of offending women (Heslehurst *et al.*, 2011; Schmied *et al.*, 2011; Knight-Agarwal *et al.*, 2014; Lavender & Smith, 2016). In this respect Smith, Cooke and Lavender (2012) suggest 'obesity' is a conversation stopper with midwives feeling reluctant to introduce the topic of BMI due to concerns they will offend women and harm the relationship. In fact, midwives say they feel vulnerable in that they are the first person to broach the subject of weight with larger women which makes them very self-conscious in doing so (Heslehurst *et al.*, 2013).

Studies suggest midwives find it so difficult to find the right words to talk about body size that they often resort to using leaflets to help them avoid initiating conversations about weight (Smith, Cooke & Lavender, 2012). Research with midwives suggests that, although they may be sensitive in terms of upsetting women, they are nonetheless keen to inform women about the risks of 'excess' weight in pregnancy as they view this as part of their role in assisting women to make informed choices (Heslehurst *et al.*, 2013). Smith, Cooke & Lavender (2012) argue that, although midwives see information-giving as an important aspect of their role in the antenatal period, they also lack confidence in the area of weight-related issues and in particular lack of knowledge about 'obesity'. Therefore, it may also be difficult for midwives to support women effectively, even if they overcome the barrier of initiating a weight-related discussion with women.

Talking about weight-related issues has also been identified as more challenging in comparison with other risk related pregnancy issues, such as smoking and alcohol consumption (Furness *et al.*, 2011; Heslehurst *et al.*, 2011; Schmied *et al.*, 2011). Furthermore, Knight-Agarwal *et al.* (2014) identify that talking about 'maternal obesity' was similar to discussing HIV infection at a time when HIV was a highly stigmatised condition. This seems to suggest that midwives are sensitive to the stigma associated with 'obesity' compared to other health related behaviours in pregnancy. In this respect midwives may feel reluctant to discuss weight in relation to risk in pregnancy out of concern that there is little emotional support offered to women in such situations (Heslehurst *et al.*, 2011). Perhaps unsurprisingly, the issue

of communication has been identified as an urgent training need for midwives who want support on how best to raise the topic of 'obesity' and weight-management with larger women.

Studies have also noted that MHP' own body size has a bearing on communication with larger women. Knight-Agarwal *et al.* (2014) found that larger midwives may be reluctant to discuss weight-related issues with larger women. The same authors describe this situation as "the elephant in the room" (p.141). Schmied *et al.* (2011) similarly report that larger midwives feel they are not good role models, and one midwife describes the scenario in these terms: "like I'm overweight. You know, how can I sit there and tell this lady about her weight when I'm overweight?" (p.427). Although larger MHP may feel self-conscious about what they might see as their own failings in relation to regulating their body size, some research also suggests slimmer MHP feel self-conscious about their bodies when discussing weight-related issues with women who are obviously 'obese' (Foster & Hirst, 2014). Guidance for midwives from the Royal College of Midwives (RCM) entitled: "Let Them Eat Cake?" (RCM, 2014), while providing potentially helpful information for midwives about raising the topic of weight (including encouraging midwives to use self-disclosure to communicate empathy with larger women), also reinforces the stereotype of 'fat women' as greedy, using imagery of an obviously very large woman pictured alongside cakes and sweets.

In contrast to concerns about taking a sensitive approach to weight-related conversations with pregnant women, research has also identified differences in the approaches taken by obstetricians and midwives, with some midwives commenting that they feel obstetricians take a very direct and matter-of-fact approach to such conversations which may not be as sensitive as they would like (Knight-Agarwal *et al.*, 2014). This difference may be due to the concerns midwives have about developing trust and communicating support with women; however, this area is under-researched. Body size seems to have a less than straightforward bearing on interactions in clinical spaces. The level of negative emotions felt by both larger women and MHP in relation to talking about weight-related issues appears problematic, suggesting further examination in this area is required.

2.8.5 Thorny issue 2: large women's bodies as a barrier to the foetus or the object of over-medicalisation?

A very interesting but under-researched area reflected within the MHP research relates to the ways women's bodies are constructed by MHP. These studies bring into sharp focus the ways larger women's bodies are framed as a barrier to providing adequate care. For example the MHP in Schmied *et al.*'s (2011) study complained of difficulty in identifying the position of the foetus due to the layer of fat on larger women's abdomens and also within the vagina. Other MHP identified ultrasound scanning as challenging, with some of the study participants saying: "we make the best of a bad job" (p.427), suggesting MHP may feel somewhat helpless in this situation.

Similarly, epidurals and cannulation[28] (which are required for some obstetric interventions) have also been described as difficult due to 'excess fat' preventing clear access to areas of the body (Heslehurst *et al.*, 2007; Schmied *et al.*, 2011). Other research also mirrors these findings, highlighting the feeling of resentment which some midwives expressed when larger bodies present challenges to their clinical skills and they are forced to seek medical support: again, leaving them feeling somewhat "helpless" (Singleton & Furber, 2014: p.6). In the same study however, midwives also suggested that often larger women's pregnancies were over-medicalised, leading to a "cascade of intervention" (p.106), suggesting this is a somewhat grey area for midwives.

The midwives in Heslehurst *et al.'s* (2013) study also felt torn in relation to their role with larger women. On one hand they felt compelled to act as an advocate for larger women, promoting pregnancy and childbirth as natural physiological processes and promoting confidence in women's ability to trust their body. On the other hand they felt obliged to follow guidelines restricting women's birth choices by involving the medical input of the obstetrician. Singleton and Furber (2014) also describe the challenges midwives face in trying to support the natural physiological processes which facilitate a 'normal' delivery (i.e. without medical intervention) in the context

[28] Cannulation describes the introduction of a thin tube into a vein to allow access to the bloodstream (Oxford Dictionary, 2018).

of a ‘high-risk labour’. The study findings demonstrate that, on one hand, midwives are critical of increased medical monitoring during labour (such as continual foetal heart monitoring using scalp electrodes), while on the other hand they are also quite unsure of the implications of reducing monitoring during labour.

2.8.6 Thorny issue 3: large women’s bodies as at risk or posing risk?

Larger women’s ability to mobilise and support their own bodies has also been highlighted within the healthcare literature. MHP report incidences whereby, handling larger women’s bodies resulted in occupational injuries (Schmied *et al.*, 2011; Knight-Agarwal *et al.*, 2014). In these studies women’s bodies are constructed as somewhat unwieldy and larger women are criticised when they are unable to support their own weight. In relation to intrapartum care, Singleton and Furber (2014) suggest that midwives seem to be tolerant of larger body size, providing it does not impact on women’s ability to support their own bodies. However, when mechanical lifting aids are required this is not welcomed by the professionals involved (Schmied *et al.*, 2011). Moreover, Singleton and Furber (2014) report that MHP may feel a sense of dread if they have to assist a woman who cannot manage alone. In one case, for example, a midwife stated: “I dread it because I can't position her, I can't lift her legs, I can't bend her legs, and I can't examine her” (p.106). It is clear from this quote the MHP is highly concerned with gaining access to particular parts of the body. The woman does appear to be somewhat in the way, in that her body is not as pliable, or compliant, as the MHP would like. As with other studies which discuss moving and handling larger women, there appears to be a lack of theoretical engagement relating to this particular framing of the larger body, and therefore this aspect of MHC is underexplored.

Although ‘excess fat’ is more often blamed for the difficulties MHP face in clinical contexts, on occasions MHP cite inadequate equipment as particularly problematic. For example, the MHP in Schmied *et al.*'s (2011) study complained that the needles provided in epidural packs were too short. Blood pressure cuffs have also caused some contention, with midwives complaining that ill-fitting cuffs produce inaccurate readings (Schmied *et al.*, 2011; Foster & Hirst, 2014; DeJoy & Bittner, 2015). Some

authors suggest women's comfort and safety during examinations, surgery, and post-operatively is compromised by inadequate equipment. For example, Heslehurst *et al.* (2011) and Schmied *et al.* (2011) both identify issues with theatre tables, trollies and beds which are unfit for purpose and the inadequate provision of moving and handling equipment. They argue that equipment, which is not fit for purpose, places both women and MHP at risk.

This situation perhaps reflects what midwives have described as a 'blame culture' which they say is a prominent feature of risk-averse maternity settings. To this effect Singleton and Furber (2014) report that midwives have raised the issue of women being identified by their weight rather than their name, therefore, becoming objectified by their size. Another aspect of the blame culture relates to the injuries which MHP say they have sustained due to either a lack of equipment for use in moving and handling larger women (Smith, Cooke & Lavender, 2012) or from having to support women's limbs during childbirth (Dotti & Maher, 2009; Schmied *et al.*, 2011; Knight-Agarwal *et al.*, 2014).

2.8.7 Thorny issue 4: 'creeping normality'

Schmied *et al.* (2011) use the metaphor of 'creeping normality' to describe the cultural shift which MHP say has taken place in general society. These authors argue that maternity services have had to adapt their practices to accommodate the greater numbers of women classified as 'overweight' or 'obese'. One of the ways they have responded to these changes is to increase the cut-off points for referral to specialists such as the dietician and anaesthetist, creating the illusion that large women do not require these additional services. Furthermore, Furness *et al.* (2011) report that, as the numbers of women becoming 'obese' increase, larger women now use other larger women as a reference point rather than slimmer counterparts. According to Furness *et al.* (2011) this has contributed to a situation whereby larger women are failing to notice they are 'overweight'. Schmied *et al.*, (2011) also identify the notion of 'creeping normality', arguing both MHP and women now see embodied largeness as 'normal'. However, these authors also note that MHP actively resist the notion that embodied largeness is 'normal', arguing 'maternal obesity' has cost implications which many feel are unacceptable.

Foster and Hirst (2014) further argue that, as ‘maternal obesity’ places mothers, babies and MHP at risk, more needs to be done to educate women about these risks prior to pregnancy, in order larger women can reduce their weight prenatally. This does seem to suggest that although the notion of creeping normality may indicate that larger women are now considered to be the ‘norm’, there does not appear to be a similar pattern of ‘creeping acceptance’. In fact, in relation to caring for larger women, Schmied *et al.* (2011) found some very negative MHP attitudes toward larger women including “repulsion” (p.426).

2.8.8 Thorny issue 5: women lack the knowledge and skill to address weight problems

Knight-Agarwal *et al.* (2014) argue that many midwives perceive women as poor eaters with little knowledge of healthy nutrition. Similarly, Furness *et al.* (2011) found that many midwives felt larger women lacked the knowledge and skill to maintain a healthy lifestyle, for example some midwives felt women lacked basic cooking skills. This review does seem to suggest that midwives view larger women through a deficit model. In the same study, the authors suggested larger women were also understood as failing to lose weight because they: “don’t want to put the work in” (p.4). Similarly, the MHP in Knight-Agarwal *et al.'s* (2014) study argue that depression is a feature of embodied largeness, perhaps suggesting the larger women in their care are viewed as lacking in the ability to deal emotionally with their weight or weight-related issues. Indeed there generally seems to be a high level of intolerance towards caring for larger pregnant women (Heslehurst *et al.*, 2011; Schmied *et al.*, 2011) which some authors say is related to the notion larger women will be unresponsive to support and advice relating to weight-management practices (Lavender *et al.*, 2001).

Having set out the review of the literature exploring MHP views on caring for larger women, in the next section I turn to the literature examining larger women’s experiences of MHC.

2.9 Current knowledge about larger women's experiences of pregnancy

2.9.1 Introduction

Schmied and Lupton (2001) suggest healthcare literature tends to neglect women's embodied experiences of pregnancy in favour of explorations of the clinical aspects of pregnancy care. The *Refreshed Framework for Maternity Services in Scotland* emphasises the provision of maternal care which is: "person centred, safe and effective, and of equitable quality regardless of the circumstances and characteristics of individual women and families" (Scottish Government, 2011: p.9). However, despite these aims there does seem to be very little interest in the experience of 'maternal obesity'. In fact, at the time this review was conducted, a meta-analysis (see, Smith & Lavender, 2011) found only six good quality studies examining larger women's experiences of pregnancy, pregnancy embodiment and maternal care, indicating how little research has been conducted in this area. Furthermore, although there are a small number of studies set within the UK, none of these are set in Scotland: therefore, this represents a gap in knowledge on which MHP can develop and improve their practice.

More recently, a small number of further studies have been published. These studies have as their focus larger women's perspectives, the MHP perspective, or a combination of both. However, interest in women's experiences is still very sparse, and many of the studies which have been conducted tend to be motivated by a desire to find ways of influencing women to change, rather than exploring the experience of pregnancy more holistically. I also found a dearth of studies that bring together women and MHP experience more theoretically with the aim of developing a deeper understanding of the ways maternity care shapes the experience of pregnancy.

In Section 2.9 I review the existing literature examining the experience of pregnancy in relation to larger women in detail. The review includes mainly healthcare literatures, but I also introduce some sociological writing to tease out some of the issues further. I pinpoint the areas previous studies have highlighted as problematic. In reviewing this literature, I pay particular attention to where contradictions, tensions, gaps or silences exist. The aim of this section of the review is to identify

aspects of pregnant embodiment and experience MHC which require further exploration in order to provide a focus for the study.

2.9.2 An overview of the research to date

Previous research exploring larger women's experience of maternity healthcare most often takes a constructionist approach involving a range of qualitative methodologies (Smith & Lavender, 2011). Furthermore, most of this research draws on interviews conducted with women either during pregnancy, or during and following pregnancy (e.g. Nyman *et al.*, 2010; Furber & McGowan, 2011; Furness *et al.*, 2011; Mills, Schmied & Dahlen, 2013; Heslehurst *et al.*, 2015; DeJoy, Bittner & Mandel, 2016). All of these studies involve face-to-face interviews with the exception of DeJoy, Bittner & Mandel, (2016) who used telephone interviews. One study also includes midwives' experiences and views using focus groups and interviews (Schmied *et al.*, 2011).

With the exception of Keenan and Stapleton (2010) and Bombak, McPhail and Ward (2016), who all draw on Foucauldian concepts to frame their analysis, the studies I reviewed do not apply specific theoretical frameworks. DeJoy, Bittner and Mandel (2016) and Nyman *et al.* (2010) take a phenomenological interpretive approach to analysis, examining the meaning of experiences during pregnancy. The remaining studies are what could be described as qualitative descriptive research. According to Sandelowski (2000), "[q]ualitative descriptive studies aim to examine events" (p.334), and often involve less interpretation than other qualitative methods, meaning researchers need not "move as far from or into their data" and "do not require a conceptual or otherwise highly abstract rendering of data" (p.335).

There has been a somewhat higher level of interest in studying the maternity experiences of larger women in UK healthcare settings compared with other Western countries, with four of these studies being conducted in England (Keenan & Stapleton, 2010; Furber & McGowan, 2011; Furness *et al.*, 2011; Heslehurst *et al.*, 2015). The remaining studies were conducted in Sweden (Nyman *et al.*, 2010), Canada (Bombak, McPhail & Ward, 2016; McPhail *et al.*, 2016) (both these publications draw partly on the same data set), the USA (DeJoy, Bittner & Mandel,

2016), and Australia (Schmied *et al.*, 2011; Mills, Schmied & Dahlen, 2013). These studies all problematise 'maternal obesity' in terms of maternal, infant and MHP risk. With the exception of studies drawing on Foucauldian concepts, the majority of authors do not identify the Othering of larger women as potentially problematic in terms of women's experience of their pregnancy, childbirth and maternal subjectivity/identity.

2.9.3 Thorny issue 1: BMI, weight-gain and pregnancy

It has been suggested pregnancy can be a time in a woman's life when she feels more comfortable about her body, as pregnancy is perceived as a time when it is more permissible to gain additional weight (Nash, 2012a). However, in relation to women who are medically classified as 'obese' prior to pregnancy, there appears to be far less social acceptance relating to embodied largeness (Smith & Lavender, 2011). Furthermore, in the context of maternal healthcare, studies suggest both women and MHP feel high levels of frustration in relation to weight-issues and weight-gain during pregnancy (e.g. Nyman *et al.*, 2010; Furber & McGowan, 2011; Furness *et al.*, 2011; Schmied *et al.*, 2011; Heslehurst *et al.*, 2015). In particular larger women have reported that interactions with MHP make them feel more self-conscious about their size (Nyman *et al.*, 2010).

Research with MHP in the UK and Australia suggests that MHP say larger women lack knowledge about the potential effects of 'obesity' on their pregnancies: so much so, they are unconcerned about their weight prior to pregnancy (Furness *et al.*, 2011; Schmied *et al.*, 2011). Meanwhile, research with women within the UK, suggests, in contrast, larger women are acutely aware of their bodies and size prior to and during pregnancy (Furber & McGowan, 2011; Heslehurst *et al.*, 2015). Furthermore, studies exploring weight-gain and body image in pregnancy in Australia suggest women carry their more general concerns about weight into pregnancy (Nash, 2012a).

In the same vein, Heslehurst *et al.* (2015) suggest when larger women become pregnant they have often experienced lifelong concerns about their weight, including multiple unsuccessful attempts to lose weight. Due to these past experiences, women may be acutely self-conscious about their bodies prior to becoming pregnant.

Moreover, Heslehurst *et al.* (2015) argues that previous negative healthcare experience may take on a special significance during a 'high-risk pregnancy', due to larger women's feelings about potential pregnancy complications related to body size. However, these authors also argue not enough attention is paid to the relationship between past healthcare experiences and the experience of maternal care. Therefore, they suggest, MHP need to communicate an empathic understanding of women's weight-related history in the context of the current pregnancy.

2.9.4 Thorny issue 2: weight as the focus of care

With the intense focus on weight-related complications in pregnancy it is perhaps not surprising that some research suggests women complain weight becomes the focus of their care, so much so, it detracts from the experience of pregnancy (Nyman *et al.*, 2010; Mills, Schmied & Dahlen, 2013; DeJoy, Bittner & Mandel, 2016). On this note, larger pregnant women have been found to deeply resent the amount of interest given to their weight, complaining it leaves them feeling alienated (Nyman *et al.*, 2010), provoking strong negative emotions related to previous negative weight-related experiences (DeJoy & Bittner, 2015; Heslehurst *et al.*, 2015). DeJoy, Bittner and Mandel (2016) argue that when weight becomes the focus of women's care it has the effect of reducing them to their weight, rendering them "just a number on the scale" (p.3).

DeJoy and Bittner (2015) suggest the emotions associated with weight-related issues, when combined with the 'high-risk status' of the pregnancy, may also encourage women to engage in health damaging behaviours such as comfort eating and withdrawal from antenatal care. Moreover, Furber and McGowan (2011) suggest the restrictions placed on larger women during 'high-risk pregnancies' may leave women feeling disempowered, due to lack of choice with respect to birth planning. In fact, larger women have complained there is such an intense focus on the potential risk of harm to the foetus in the context of 'maternal obesity' they feel marginalised as people and argue this situation is discriminatory (Bombak, McPhail & Ward, 2016). Both Furber and McGowan (2011) and Bombak, McPhail & Ward (2016) highlight in these circumstances, women feel a deep sense of 'mother blame'.

Elsewhere in the literature there is growing evidence the discourse of 'mother blame' has emerged from mainstream anti-obesity thinking, positioning larger women as irresponsible in relation to the perceived risks to their unborn child from maternal body size (Bell, Mcnaughton & Salmon, 2009; Keenan & Stapleton, 2010; McNaughton, 2011; Warin *et al.*, 2011; McPhail *et al.*, 2016). The relationship between discourses of risk, maternal obesity and mother blame have only relatively recently been identified in social science literature and, as yet there are no studies examining the context of maternal healthcare and larger women's experience of a 'high-risk pregnancy' which take the notion of mother blame as the focus of analysis in the UK context. The scholarship examining the concept of 'maternal obesity' and 'mother blame' is examined in more detail in Chapter 3 as a promising lens for a critical examination of larger women's experience of maternal healthcare.

2.9.5 Thorny issue 3: talking about weight

As I drew attention to in Section 2.5, the 'high-risk status' of larger women's pregnancies increases the contact women have with MHP (NHS QIS, 2009). Midwives are the first point of contact for all pregnant women and they continue to have regular contact with women over the duration of pregnancy. However, research with larger women about their experience of MHC in the UK has highlighted significant difficulties in relation to weight-related issues and communication (Furber & McGowan, 2011). Both verbal and non-verbal communication have a special significance in relation to healthcare consultations, especially in relation to gaining consent for medical procedures (NHS QIS, 2009). However, research from the UK suggests both women and MHP have conflicting views of the nature and content of the information they are given in relation to lifestyle issues and weight-management. On one hand larger pregnant women have said they often receive insufficient, incomplete or inconsistent information, while on the other hand MHP report that giving information to larger women is futile, due to the perception larger women are unmotivated or lack the skills necessary to maintain their weight within acceptable levels (Furness *et al.*, 2011).

According to Keenan and Stapleton (2010), women are often blamed by midwives as being reluctant to discuss weight-related issues However, some studies suggest

women may not discuss weight-related issues with midwives because they fear the judgmental attitudes which are often conveyed during weight-related discussions (Mills, Schmied & Dahlen, 2013). Furthermore, women say midwives may not have the level of knowledge to effectively discuss eating difficulties with them, and therefore, they are provided with contradictory information, especially in relation to weight-gain expectations. However, despite the lack of sensitivity which some women feel midwives show in relation to these issues, women say they want to talk about weight-gain and value honesty.

Furthermore, because MHP may avoid talking about weight-related issues sometimes women report that they have been referred to other services and/or for clinical procedures without their knowledge or consent (Furber & McGowan, 2011). Other UK research suggests both written and verbal communication with larger pregnant women is an area which appears to be inherently problematic for practitioners. This is especially so around language use, with a good deal of uncertainty about how to broach weight-related subjects (including lifestyle factors) and also in relation to the selection of words used to describe the body during physical examinations (Furber & McGowan, 2011). Women say the use of euphemisms and technical language to discuss weight-related issues is somewhat patronising (Mills, Schmied & Dahlen, 2013).

Recording information in the hand held notes has also been identified as problematic in some studies. Some of the participants in Furber and McGowan's (2011) study felt very embarrassed when there was dissonance between what was said to the women during sonography procedures, and what was written in the SWHMR (NHS Healthcare Improvement Scotland, 2011). Women also describe feeling embarrassed and humiliated by the comments which MHP wrote in their records, especially in cases where weight is frequently referred to (Furber & McGowan, 2011). These studies seem to suggest there may be a lack of awareness about the effects of stigmatising language.

2.9.6 Thorny issue 4: making assumptions

The literature review highlighted that larger women felt MHP made assumptions about their body's capabilities and also their lifestyles (Nyman *et al.*, 2010; Furber & McGowan, 2011; Smith & Lavender, 2011; Heslehurst *et al.*, 2015). Some of these studies suggest that MHP had low expectations of how larger women's bodies would perform in pregnancy. For example, DeJoy, Bittner and Mandel (2016) reported that women felt MHP assumed their pregnancies would be complicated with various problems, and as a result of these assumptions, they felt they received depersonalised treatment. Furthermore, DeJoy, Bittner and Mandel (2016) also reported that some women felt so negatively about the care they received this led to care avoidance. Women have also said they feel their experiences are either ignored or not believed. For example, the women in Nyman *et al.'s* (2010) study said they felt they were not believed when reporting foetal movements, and therefore, these women were subjected to further medical examinations. In the same vein, DeJoy, Bittner and Mandel (2016) reported that women found the level of surveillance involved in their pregnancies difficult, and this was compounded by being subjected to multiple repeated tests following negative test results. In this situation the women believed MHP expected that at some point the negative test results would become positive. In these situations these women felt they had no choice but to comply with MHP wishes.

Women have also said they feel exasperated about the assumptions MHP made about their physical capabilities, including the belief that larger women are reluctant to mobilise after surgery (Furber & McGowan, 2011). As I discussed in Section 2.8.6, when MHP consider factors connected with mobility, they tend to think in terms of safety related issues for themselves, particularly in relation to moving and handling issues (e.g. Schmied *et al.*, 2011) and this may have a bearing on this situation.

Perhaps the most problematic, in terms of assumptions made about larger women, seems to be lifestyle issues. Some studies demonstrate, as women expect to have to defend themselves against criticism about their weight and size, they offer explanations even when not asked to do so (Heslehurst *et al.*, 2015). Furthermore, women also complain that MHP show surprise on discovering their lifestyles are

what would be considered healthy (Heslehurst *et al.*, 2015). Meanwhile, other studies highlight larger women feel MHP make assumptions about their lifestyles, rather than taking time to enquire about their eating and activity preferences (Nyman *et al.*, 2010; Furber & McGowan, 2011; Heslehurst *et al.*, 2015; Mills, Schmied & Dahlen, 2013; DeJoy, Bittner & Mandel, 2016).

In addition to lifestyle factors, women also report that assumptions are made about weight-gain in pregnancy. For example, the women in Furber and McGowan's (2011) and Furness *et al.'s* (2011) studies also felt there was a high expectation they would gain too much weight in pregnancy. Furthermore, some women report becoming distressed by frequent references to the size of their baby during both ultrasound screening and abdominal palpations. These feelings were compounded when all the women went on to deliver 'normal' weight infants in labours which were highly medicalised.

This aspect of the literature review does seem to suggest the assumptions, which larger women feel MHP make about them, may lead to them feeling misunderstood, particularly in relation to their lifestyles and the capabilities of their bodies. It is clear larger women feel a range of assumptions are made about their bodies and lifestyles which link to a variety of negative healthcare experiences. Nyman *et al.* (2010) suggest a greater level of mutual understanding is required to enable MHP and larger women to work together to overcome the many misunderstandings which, they argue, greatly impact on larger women's experience of pregnancy. They further argue it is of upmost importance to ensure women's embodied experiences are considered in the context of maternal health provision, demonstrating the need for individual and sensitive caregiving in which "the women can tell their own story" (p.429).

2.9.7 Thorny issue 5: embodiment, objectification and depersonalisation

The literature exploring women's experiences of MHC also suggests the intense focus on monitoring the growth of the foetus can cause additional negative emotional experiences for larger women. The process of being scanned has been identified as particularly objectifying and also painful. Women complain that, as the

sonographer's only concern is viewing the baby, the transducer tends to be pushed so hard into the abdomen they feel dehumanised (Furber & McGowan, 2011; Furness *et al.*, 2011; Mills, Schmied & Dahlen, 2013). Women also report feeling guilty during clinical examinations in which the MHP is unable to assess foetal growth or progress (Nyman *et al.*, 2010; Furber & McGowan, 2011). Ultrasound scanning has been noted as being a pivotal moment in the adjustment to parenthood (Ekelin, Crang-Svalenius & Dykes, 2004). However, ultrasound examinations can be very anxiety provoking, because often women associate them with the identification of foetal abnormalities. In this respect, Nordvig *et al.* (2006) suggest this is especially so if the scan results are ambiguous.

Along with scans, women also find cardiotography (CTG)[29] monitoring difficult, especially when it is obvious their abdominal fat is in the way, again provoking intense feelings of guilt and shame (Nyman *et al.*, 2010; Mills, Schmied & Dahlen, 2013). Women also report feeling very anxious during clinical examinations, worrying that equipment might be unsuitable. In this regard women may feel very self-conscious about the size of their bodies (e.g. Nyman *et al.*, 2010; Furber & McGowan, 2011; Smith & Lavender, 2011; Mills, Schmied & Dahlen, 2013). It is also worrying to note that some women also report MHP are reluctant to touch them and this heightened their own feelings of self-disgust (Mills, Schmied & Dahlen, 2013). In relation to embodiment, women also report that, although the discomforts of pregnancy may be somewhat magnified by being larger at the onset of pregnancy (Mills, Schmied & Dahlen, 2013), there was also a lack of information about the larger body in pregnancy. Therefore, women must rely on information which is not specific to their needs (DeJoy, Bittner & Mandel, 2016).

2.9.8 Thorny issue 6: embodiment and risk

Some studies suggest women find the additional medical interest, which they incur during a 'high-risk pregnancy', reassuring. However, Lee, Ayers and Holden (2012) point out that such studies may neglect the contextual factors involved in provoking these feelings. Studies in the US and the UK involving women labelled as 'high-risk'

[29] CTG is an abbreviation of cardiotocography which is a medical technology used to monitor the foetus' heartbeat and the mother's contractions while the foetus is within the womb (Tiran, 2017).

suggest larger women may avoid care, due to the increased emphasis on complications and medicalisation associated with such pregnancies (DeJoy, Bittner & Mandel, 2016). Care avoidance may make women feel better in the short term: however, doing so can also can lead to health complications and poorer pregnancy outcomes (Scottish Government, 2011).

More specifically, studies looking at larger women's experiences suggest 'high-risk pregnancies' often increase the feelings of objectification and depersonalisation which women feel as a consequence of medicalisation (Nyman *et al.*, 2010; Furber & McGowan, 2011). For example, the women in Furber and McGowan's (2011) study felt the 'high-risk status' of the pregnancy had the effect of increasing the focus of the medical care onto the foetus, rather than on the mother and foetus as a unit. Similarly, Nyman *et al.* (2010) found women felt a heightened sense of their body during pregnancy which was intensified during clinical procedures. This was particularly so when MHP were very concerned with risk. Furthermore, the women reported feeling a strong sense of disembodiment with an increased sense of depersonalisation which they felt reduced them to the status of "human incubator" […] "just a statistic" (p.426).

Additionally, the women in DeJoy, Bittner and Mandel's (2016) study felt MHP tended to over exaggerate the risks associated with their pregnancies. This was especially so when women were informed with great certainty that they were likely to develop pregnancy complications. In the same vein, some women said they were also informed they should expect to have big babies, and therefore, would almost certainly require assisted births or caesarean sections. This type of interaction intensified the guilt and shame women already felt in relation to body size, also making them feel more vulnerable and dependent on their caregivers (Lee, Ayers & Holden, 2012). According to Mills, Schmied and Dahlen (2013) the 'high-risk' label may also have the effect of increasing the levels of disgust which some larger women have towards their bodies. For this reason, Furber and McGowan (2011) suggest more attention needs to be given to the emotional aspects of larger women's pregnancy experience, particularly as larger women may feel personally responsible for the 'high-risk status' of their pregnancy. This is especially so, as women have

said the experience of their current pregnancy was likely to influence how they anticipated future pregnancies and pregnancy care (DeJoy, Bittner & Mandel, 2016). This suggests maternal care experiences have far-reaching implications for women's lives.

2.9.9 Some limitations and further considerations

In this section I draw attention to some of the limitations of literature exploring larger women's experience these are particularly helpful in identifying areas requiring further examination. For example, Mills, Schmied and Dahlen (2013) explored weight-stigma in maternity settings and, despite careful consideration to the language used to talk about larger bodies, it is notable the interviews were reported as lasting between 15 and 60 minutes. As the interview guide included a wide range of questions, it can only be assumed some of the participants were reluctant to talk about some of the issues. The reported study was, in part, looking at readiness for change so it is possible the women may have felt defensive, especially as so much of the research in this area highlights the assumptions made about larger women. It may be research with a 'motive' like this obscures or misses aspects of the pregnancy experience which would be better explored by being more open to women's experiences.

Some of the studies which draw on a Foucauldian inspired lens highlight significant concerns relating to the emotional aspects of women's experience of 'maternal obesity'. Although Foucauldian inspired work deals with the political aspects of understanding women's experience, there are some limitations. Lupton (2012a), for example, argues that research inspired by Foucauldian concepts can neglect the emotional aspects of subjectivity and, therefore, further research is needed which examines "how bodies, practices, discourse, technologies and objects interact" (p.9). The quote from Lupton's (2012a) suggests methodological and theoretical implications indicating a need to bring together embodiment and sociocultural context. I will consider these issues further in Chapter 3 where I discuss a potential way for theoretically framing the study of larger women's pregnancies in a way which converges these aspects of experience.

2.10 Chapter summary

In conducting this review I found the medical literature was dominated by a reductionist approach which is primarily concerned with the identification and management of risk (Williams, 2012). This framing reflects the assumption larger women's bodies will 'fail' in relation to pregnancy and childbirth. However, the review also captured some of the contradictions contained within the medical literature, revealing some interesting debates which point towards various tensions problematising the medical framing of the larger pregnant body.

The review of the healthcare literature relating to MHP views about their practice with larger women revealed several areas requiring further exploration. Firstly, most of the studies I reviewed rarely involved obstetricians, and yet, obstetricians are highly involved in the care of larger women. Therefore, more needs to be known about how their understanding of the larger pregnant body shapes their practices. In examining the literature relating to research with MHP I also found several 'thorny' aspects in relation to larger women's care. I also noted that, although the condition of 'maternal obesity' was positioned as inherently risky, none of these studies problematised the way 'maternal obesity' was constructed and acted on in medical spaces. Therefore, the review suggests further research is required which takes a more critical approach to render a fuller examination of the context of MHC.

In reviewing the small numbers of studies exploring larger women's experiences of pregnancy and maternal care, I noted evidence to suggest larger women often feel they are treated less favourably than slimmer women. Some studies suggest women are acutely aware of the moralistic stance which may be taken by MHP, and which may be used to legitimise the medicalisation of their 'high-risk' pregnancies. Furthermore, I noted increased medical involvement potentially induces further emotional demands for larger women, and yet, studies also suggest women's experiences and feelings are marginalised. The review suggests the concept of mother blame may have some relevance in relation to how both MHP and larger women feel in clinical situations, and may be especially pertinent in relation to the emotional demands of a 'high-risk pregnancy'

I also noted in reviewing the literature exploring larger women's experiences that many of these studies took an uncritical approach to the subject of 'obesity'. Authors also tended to view risk in absolute terms. For example, many of the studies I reviewed present a straightforward account of how dangerous such pregnancies are. Studying experience framed in this way leaves a gap in terms of understanding how the context of maternal healthcare shapes embodied pregnancy experience. Furthermore, I noted that when researchers align their work with mainstream understandings of 'maternal obesity' they also obscure alternative ways of examining and understanding the experiences of larger women. Mainstream anti-obesity perspectives often also lack political and critical sociological insights which alternative lenses can provide. As I will discuss in Chapter 3 body size is inherently political (Oliver, 2006) and needs to be considered in relation to the study of embodied largeness.

Bringing together the research from medical perspectives and the literature examining MHP and larger women's views and experiences it seems clear there is very little convergence or mutual understanding of embodied largeness in the context of pregnancy. The review also demonstrates MHP take multiple positions in relation to larger women, and they draw on a variety of discourses including mainstream obesity discourse, and maternal obesity discourse. Therefore, conceptualising the context of maternal care as a discursive context has real potential in revealing the ways women are understood in this context. It is likely that larger women view their pregnancy, embodiment, and experience of maternal healthcare differently from MHP, and they draw on alternative discourses to understand their embodied experience. Consequently, examining the intersection of embodied experience and the context of MHC is likely to produce knowledge which illuminates 'maternal obesity' from multiple perspectives. Taking such an approach has the potential to disrupt taken for granted knowledges and assumptions, providing the means to foster mutual understanding and care improvement.

The review therefore, suggests further theoretical exploration is required to illuminate more fully how the larger pregnant body is constructed and understood. In

the following chapter I draw on social science writing on the larger pregnant body to position my approach to the current research.

Chapter 3 Thinking about and with the body

3.1 Introduction

In this chapter I set out my thinking in relation to the body, proposing a means to conceptualise the body and embodiment which takes account of the body as 'material' and 'discursive'. My approach in relation to theory could be defined as a 'bricolage' (Denzin & Lincoln, 2000) in that I draw on a variety of theoretical perspectives which suit the interdisciplinary nature of my research.

I begin the chapter by problematising ontological thinking about the body and set out how I deal with thinking about the body philosophically. I then use this as a lens to explicate how the larger female body has been problematised, exploring the body as it is framed by medicine and society. I end the chapter by examining the body politic, explicating the governance of the female body and the larger female body.

3.2 The socially constructed body

The ontological position I take in relation to this research is grounded in what is termed the 'linguistic turn' and situated in social constructionism which posits that what counts as knowledge, arises from the meanings constructed from within our social relations and practices (Berger & Luckmann, 1967). Therefore, the social constructionist approach questions the existence of essential or fixed 'truths'. As 'knowledge' or 'truth claims' arise from within our social milieu, what can count as 'truth' is never static, is always situated historically and culturally, and a product of power relations which serve someone's interests (Lupton, 2012b). Following constructionist thinking, knowledge, or more correctly, *knowledges* can be conceptualised, not as independent from reality, but as active "participant[s] in the construction of reality" (Lupton, 2012b: p.9).

Although there has been increased academic interest and acceptance in constructionist approaches to the study of health and illness, the constructionist conceptualisation of the body can be a somewhat thorny issue. Lupton (2012b), for example, points out that, as this approach considers knowledge as a social product, then it follows that knowledge gained from constructionist insights needs also to be questioned. Critics of discursive approaches, therefore, draw attention to the danger

of descending into, "relativism and nihilism" (Lupton, 2012b: p.10). Secondly, it is argued, as the constructionist approach focuses on the sociolinguistic aspects of experience, the materiality[30] of the body is ignored (Yardley, 1997; Williams, 2001). Therefore, constructionists have difficulties in explaining how we can know about the material aspects of life, such as embodied experience (e.g. pain and hunger) (Yardley, 1997).

3.3 The material body

The Western biomedical[31] stance on the body sharply contrasts with the constructionist body, taking what Scheper-Hughes and Lock (1987) describe as a 'radically materialist' approach. Materialism reduces the body to an object operating according to universal laws. The philosophical assumptions of materialism rest on *Cartesian dualism*, otherwise known as mind/body dualism, which argues it is possible to reduce a person to a body because the soul or self exists independently. Conceptualising the body in dualist terms means that, as the body is not constitutive of 'the self', the body can be studied, investigated and treated as *object* (Howson, 2004). While this view has found wide acceptance allowing medicine to make significant advances (Scheper-Hughes & Lock, 1987) there are critiques of the approach. The main criticisms being that although the objectification of the body has advanced biomedical understanding of the complexity of the interior workings of the body, the dualist approach strips bodies "of their animating, dignifying, and humanising subjectivity" (Bordo, 2003: p.73). Therefore, to all intents and purposes, the body, as understood through the lens of materialism, is a dead body. The Cartesian legacy has meant that modern medicine has been dominated by materialist thinking, whereby the artificial division between mind and body creates ontological difficulties in conceptualising somatic experiences (Scheper-Hughes & Lock, 1987).

As indicated in Section 2.9, research suggests that, despite recent interest in providing 'women-centred' maternity care, women experience their bodies in dualist

[30] According to Yardley (1997), the term 'material', "signals attention to the physical features of human lives, including not only our bodies and corporeal activities, but also our environment, institutions, technology and artefacts" (p.1).
[31] I follow Lupton (1995) who defines biomedicine as, "a symbolic system of beliefs and a site for the reproduction of power relations, the construction of subjectivity and of human embodiment" (p.4).

terms (e.g. Nyman *et al.*, 2010). I also noted, during an email exchange[32] I had with one of the RAG members, that in pregnancy she seemed to experience her body in dualist terms:

> I remember resenting, to a certain extent, the separation of myself and my 'body' as if the pregnancy made my body a separate entity that belonged to others […]. Part of the problems I continually have with weight (which my rational mind knows but I can't seem to get the rest of it to grasp) is the separation of body from identity and this seemed particularly enhanced during pregnancy.

Several scholars have sought to transcend mind/body dualism: restoring the body as a unified whole. Much of this work develops the phenomenological approach of Merleau-Ponty (1962) who proposed that the body and consciousness are represented as a single unit. Phenomenologists direct attention to the way the body is conceptualised as 'body-subject' and 'body-object' (Merleau-Ponty, 1962). Body-subject represents the lived body as it is experienced, whereas, body-object relates to the body as conceptualised by science i.e. as an object of study. The approach seeks to restore the dualism this creates by suggesting the body is experienced holistically as an integral aspect of the self, i.e. 'I am my body'. Although phenomenology promises to address issues associated with mind/body dualism, the approach has its critics who argue that phenomenology neglects the interrelationship between social discourse, the institution and embodiment (Frank, 1991).

3.4 Thinking with the body

Both anthropological and feminist writers have proposed solutions to the ontological difficulties created by the constructionist and materialist body. Mary Douglas (1996), for example, suggests it is helpful to think of the body as both natural and cultural. Scheper-Hughes and Lock (1987) also view the body as "simultaneously a physical and symbolic artefact […] both naturally and culturally produced, and as securely anchored in a particular historical moment" (p.7). Conceptualising the body as having a continual relationship with society and culture produces what Scheper-Hughes and Lock (1987: p.18) term: "a body that is good to think with" (p.18).

[32] This quote is used with the full permission of the RAG member.

In the same vein, and taking a pragmatic approach, Yardley (1997), argues for a combination of discursive and phenomenological approaches in order to: "consider how the socio-linguistic aspects of experience relate to our material existence" (p.2). Grosz (1994), shares Yardley's thinking, suggesting the body is both materially experienced and socially constructed. However, Grosz (1994) also provides an interesting means in which to imagine this relationship. She suggests the body is best conceptualised as a 'möbius strip' representing the continual relationship between the inside and outside of the body with the cultural environment. Grosz's (1994) notion of the möbius strip illuminates the inter-relationship between the material body as lived or experienced, and the ways the body is culturally read or understood as an external surface (Marshall, 1996). These authors achieve what Scheper-Hughes and Lock (1987) describe as a means to think *with* the body, to transcend the ontological difficulties presented by both constructionism and materialism. In other words, these approaches provide a means to take account of the corporeality or materiality of embodiment and the body as symbolic artefact.

Scheper-Hughes and Lock (1987) take an interesting approach to thinking with the body. I suggest their approach has promise as a framework for exploring embodied largeness theoretically in the context of maternal obesity discourse and maternal healthcare. Scheper-Hughes and Lock (1987) suggest the body may be analysed according to three overlapping analytical framings: as a phenomenological body, a social body, and a body politic. The phenomenological body is the body as conceptualised by Merleau-Ponty (1962), i.e. the lived body as it is experienced. The social body is, "the representational uses of the body as a natural symbol with which to think about nature, society, and culture" (p.7). While the body politic:

> Refer[s] to the regulation, surveillance, and control of bodies […] the stability of the body politic rests on its ability to regulate populations (the social body) and to discipline individual bodies (Scheper-Hughes & Lock, 1987: p.7-8).

Although Scheper-Hughes and Lock's (1987) writing may be considered somewhat dated in relation to more recent writing from the field, their ideas continue to be drawn on, particularly in the field of bioethics. One example of the ways Scheper-Hughes and Lock's (1987) approach has been extended can be seen in the writing of

medical anthropologist Nora Jones (2011). Jones (2011) takes Scheper-Hughes and Lock's (1987) framework, producing her own novel approach to the study of the body. More specifically, Jones (2011) develops a means to: "see *through* [the body] to attitudes about bodies, health, and illness in the larger society and culture" (italics original, p.74).

Drawing on the ideas of Scheper-Hughes and Lock (1987), Jones suggests that embodiment, and the experience of health, illness and healthcare can be studied through three lenses: "body as specimen, spectacle, and patient" (p.74). Body as specimen is, "the patient body as seen by the practitioner, body as spectacle represents: the generalized ill or diseased body found in popular culture", and body as patient relates to: "the patient's understanding of her own body" (p.74). In the following sections I set out Jones' (2011) lenses before going on to explain how the rest of the Chapter is set out.

3.4.1 Body as specimen, as spectacle and as patient: an overview

According to Jones (2011), 'body as specimen' is the Cartesian body and represents the way practitioners view the body as diseased and broken. 'Body as specimen' is created in medical schools where medical students encounter dissection of the body, a procedure whereby the body is separate from the person. 'Body as specimen' is also created through its experience in medical environments. It is a product of medical examinations, becoming reduced to a disease, an organ, a classification: BMI 40 - Room 6.

The so-called 'obesity epidemic' could not exist without the classification of body size using the BMI (Fletcher, 2014). 'Body as specimen' therefore, has its own unique language learned through the study of the body as object and as disease. Such language is used in patient records and may be incomprehensible to patients. The patient record reduces the patient to organs, tests, clinical images, diagnostic labels, and provides snapshots of points in history rather than a holistic view (Jones, 2011).

'Body as spectacle' widens the view taken in the body as specimen, making the body whole again. This body links personal and visual representations of the body, it is the

anonymous body of popular culture which represents the way the body is understood: illuminating how health and illness are framed and shaped by popular culture. Drawing again on Scheper-Hughes and Lock (1987), Jones (2011) suggests, this is the body we should *think* with, it allows us to see the way we understand health, illness and healthcare through cultural and societal eyes.

'Body as patient' is the experience of the body, the experience of illness, the feelings, beliefs, attitudes and actions of ill people. 'Body as patient' expresses the worldview and identities of patients. It also sheds light on how people resist body as specimen: revealing alternative models of experiencing the body and of health and illness. According to Good (1994) the stories which people tell about their experiences as patients are the best way to access the realm of body as patient. These stories begin at the moment the healthcare practitioner tells the patient the 'diagnosis story'. Good (1994), also suggests that diagnosis stories have special significance in that they communicate to the patient the practitioner's understanding of why the patient has become ill. They also communicate the practitioner's view of how the patient is expected to respond to the diagnosis. For this reason the diagnosis story can be highly deterministic; affecting the way the patient understands themselves and their actions (Good, 1994).

I suggest Scheper-Hughes and Lock's (1987) assertion that we need to *think with the body* offers a suitable theoretical framework for dealing with the ontological difficulties I set out in Sections 3.2 and 3.3 of this chapter: providing a means to transcend dualism and the problems associated with a radically constructionist approach.

Firstly, Jones' (2011) 'body as specimen' provides a framework for examining how larger women's bodies are medically constructed by maternal MHP: illuminating how pregnant bodies and 'obese' bodies are produced. Secondly, Scheper-Hughes and Lock's (1987) lens of body politic has the potential to shed light on the medical regulation of the 'fat body', and the 'fat pregnant body'. Thirdly, Jones' (2011) 'body as spectacle' potentially provides a means to consider the broader sociocultural context in which larger bodies are constructed and understood. Lastly, Jones' (2011) 'body as patient' points towards a methodology which supports the exploration of the

sociolinguistic and embodied aspects of 'fatness' and pregnancy, along with the lived experience of healthcare. In short, *thinking with* the larger pregnant body through Scheper-Hughes and Lock's (1987) and Jones' (2011) lenses potentially provides a means to investigate pregnant embodiment, the experience of the large body and maternal healthcare, in a way which also accounts for the context in which this body is created and experienced.

I will explore methodological considerations fully in Chapter 4: however, at this juncture I note the notion of a diagnosis story has resonance with the risk assessment and care pathway approach which larger women encounter within maternity care settings. Bearing this in mind, in Section 3.7 I discuss theoretical approaches to risk in the context of pregnancy; considering how the notion of risk potentially shapes the embodied experience of pregnancy. I discuss the diagnosis story, or in other words the labelling of a pregnancy as a 'high-risk pregnancy', in relation to methodology in Chapter 4.

3.5 Body as specimen: the biomedical body

3.5.1 Cartesian philosophy and the 'fat body'

Taking forward Jones' (2011) lens of 'body as specimen', in this section I set out how embodied largeness is viewed from the biomedical perspective. Biomedical perspectives draw on Cartesian philosophical reductionist thinking which views the workings of the body using the metaphor of 'body-as-machine' (Rich & Evans, 2005). The philosophical origins of the classification of some bodies as 'obese' reveal much about the assumptions driving the medical approach to the large body. The biomedical framing conceptualises the body as operating according to natural laws: making it stable, predictable and consistent over time (Howson, 2004). From a medical perspective, viewing the body in this way renders it suitable for observation and manipulation; in other words 'fixing' (Freund & McGuire, 1999).

In relation to the large body, Cartesian 'body-as-machine' thinking reduces the body with a simplistic dualistic model of *energy balance,* whereby the intake of excess energy in the form of foodstuff and the expenditure of too little energy in the form of exercise, equates to the creation of excess fat on the body (Gard & Wright, 2005).

Importantly, the Cartesian body is based on an ontological distinction between body and mind, whereby the body is viewed as subordinate to the mind (Howson, 2004). Dualism also renders the body as inferior to the mind, which is viewed as having the ability to govern the body's demands and emotions, which are also understood as requiring discipline (Grosz, 1994). Consequently, the biomedical view of the large body, as illuminated by Cartesian dualism, constructs the slim body as a highly controlled and disciplined body (Lupton, 2013a). Meanwhile, the un-contained 'fat body' gives into "desires of the flesh" (Lupton, 1995: p.8) as evidenced by overindulgent eating and inactivity: letting yourself go, as Hartley (2001) puts it.

3.5.2 Critiquing the Cartesian framing of the 'fat body'

The obvious difficulty with understanding 'fatness' through a Cartesian lens is that the focus on the energy balance model, or the 'big two' as it is often referred to (Keith *et al.*, 2006), neglects the sociocultural, political and economic contexts in which 'obesity' is experienced, constructed and understood (Danielsdottir, O'Brien & Ciao, 2010; Puhl & Heuer, 2010). Simmons (2011) draws attention to recent evidence suggesting the development of obesity may be related to factors associated with modern living, such as, weight-gain following smoking cessation, sleep deprivation, imbalances in gut flora and 'obesity causing viral infections'. Despite this type of evidence, Rich and Evans (2005) argue that the biomedical position on the larger body ignores the more complex interactions between environment, biological and genetic factors: foregrounding instead the Cartesian body-as-machine conceptualisation which dominates public health, and health education policy and practice. The effect of this is to individualise the 'problem of obesity' with the expectation that 'good citizens' will control the body through self-discipline (Throsby, 2007; Lupton, 2012b). Meanwhile, the wider political and sociocultural influences, which also influence people's ability to exert control over their bodies, are absent from mainstream medical anti-obesity discourse (Bordo, 2003; Gard & Wright, 2005; Saguy & Riley, 2005; Lupton, 2013b; Saguy, 2013).

Although public health and biomedical discourse locate the 'problem of obesity' within individual control (Lupton, 1995; Monaghan, 2013), critical obesity scholars argue that growing research evidence suggests the weight-focused paradigm, which

advocates weight-reduction through restricting calorie intake (dieting), fails to provide long lasting solutions for 'weight-problems' (Foster & Kendal, 1994; Bacon & Aphramor, 2011). Furthermore, the cycle of weight-gain and weight-loss, which many dieters find themselves trapped in, has little to do with individual factors such as lack of willpower, and are more likely to be due to issues falling outside reductionist medical thinking (Carryer, 2001; Aphramor, 2005; Bacon *et al.*, 2005; Aphramor, 2010).

In light of these arguments a growing number of scholars have problematised the reductionist assumptions made by mainstream biomedicine; criticising the public health and medical professions for an over reliance on the dualistic energy balance model in terms of understanding the causes and solutions to 'obesity' (Bacon *et al.*, 2005; Bacon & Aphramor, 2011). Furthermore these scholars argue, weight-reduction through dieting can be critiqued as a form of iatrogenesis, whereby medical intervention is associated with further, and sometimes more serious complications, than the original problem (Illich, 1976). Critics of obesity science therefore, argue the medical reductionist approach to the 'treatment of obesity' does more harm than good (Bacon *et al.*, 2005).

3.5.3 Cartesian philosophy and the pregnant body

The female 'body as specimen' is the site of a burgeoning (pun intended) body of feminist literature in which authors draw on mind/body dualism arguing that women's bodies are the site of gender inequalities impacting on every aspect of women's lives (Tischner, 2013). Feminist authors argue that following Cartesian thinking, men are viewed as dominated by the mind and rational thought, whereas women are ruled by emotion and flesh: both of which are volatile and out of control (Grosz, 1994). Furthermore, the Cartesian position on the female body suggests that, due to women's inability to control their bodies, 'male rationality' is required in disciplining female flesh (Bordo, 2003). Oakley (1980, 1984) and Martin (1989) therefore argue that the medicalisation of women's bodies rests on dualist thinking which has provided medicine the opportunity to observe, classify and experiment on women's bodies, gathering knowledge about women's embodied experience. Women have been rendered invisible in this process (Martin, 1989). This point is

perhaps best articulated by Katz Rothman (1989) who argues: "I have come to see that it is not that birth is "managed" the way it is because of what we know about birth. Rather, what we know about birth has been determined by the way it is managed" (p.178). The knowledge generated by medicine has established the normal/not normal binary on which women's bodies are evaluated (Foucault, 1973, 1978; Armstrong, 1983). As Davis (1995) argues, women's embodied sensations may be rejected as a source of knowledge. And this seems to be particularly so in light of modern reproductive technologies which are believed to reduce the trust women have in their interpretations of embodied experience (Katz Rothman, 1988).

3.5.4 Critiquing the Cartesian framing of the pregnant body

Feminist scholarship therefore argues that, as women are reduced to mere observers of their own bodies, the medical approach to pregnancy denies women the right to produce knowledge which is suitable for understanding female embodiment (Kent, 2000). This is particularly so in the case of larger pregnant women who authors argue are rendered invisible due to the problematisation of the larger pregnant body (Tischner & Malson, 2008; McCullough, 2013; Hansen, 2014). With the exception of a few studies (e.g. Oakley, 1984; Young, 1984; Bailey, 2001; Nash, 2012a, 2012b; Ross, 2015a), feminist writers argue the study of the female body has been dominated by medicine, therefore, relatively little is known about pregnant embodiment. For example, Ross (2015) argues that early pregnancy embodiment is rarely explored and yet it may be characterised by feelings of tentativeness towards the pregnancy involving high levels of emotion work (Ross, 2018). Previous research on pregnant embodiment suggests current medical understandings of female embodiment fail to account for the change and flux of women's bodies (Davis & Walker, 2010). And this is particularly pertinent considering pregnant women often feel their bodies are out of control (Nash, 2012a). In this respect women may be simultaneously "thrilled and horrified" by the change in their bodies (Oakley, 1984: p.58). Furthermore, weight-gain in pregnancy, although considered a routine aspect of pregnancy, may be quite problematic for some women and may be strongly influenced by previous weight-related experience (Nash, 2012b).

The lens of 'body as specimen' potentially provides a means to explore medical reductionist approaches to the large pregnant body in the context of maternal healthcare. Conversely, the literature critiquing the Cartesian approach to both the 'fat body' and the pregnant body suggests that understanding female embodiment involves investigating the 'lived body', or 'body as patient' (Jones, 2011). The critique of the 'body as specimen' also suggests a lens which broadens the reductionist medical approach into the social realm. Therefore, in the next part of this chapter I draw on Jones' (2011) notion of 'body as spectacle' to explore the large pregnant body from a sociocultural perspective drawing further on sociological and anthropological writing and the work of feminist and critical fat scholars.

3.6 Body as spectacle: the sociocultural framing of the 'fat body'

> In and of itself, fat has no meaning- It is the specific historical, social and cultural context in which fatness is lived, experienced, portrayed and regulated which give it meaning, just as other bodily attributes or features such as skin or hair colour, youth and height take on certain meanings depending on their context (Lupton, 2013a: p.3-4)

The above quote highlights the socially constructed nature of body-size and suggests body size can only be understood in a way current sociocultural framing will allow. In this section I think *with* the body (Scheper-Hughes & Lock, 1987), considering 'body as spectacle' (Jones, 2011) by exploring the social, cultural, media, and medical representations of the larger body.

In considering the body, anthropologist Mary Douglas (1966) views it as a symbol of society on which societal rules are inscribed. As Bordo (2003) puts it, the body is a "metaphor for culture […] a powerful symbolic form, a surface on which the central rules, hierarchies, and even metaphysical commitments of a culture are inscribed" (p.165). Following this thinking, several prominent authors have conducted detailed analysis of contemporary representation of the large body arguing it has come to stand for poor health, unattractiveness, gluttony and sloth (e.g LeBesco, 2004; Evans, 2006; Murray, 2008). One of the forms this representation takes is articulated visually through the phenomenon of the 'headless fatty' which fat activist Charlotte Cooper first described in 2007. Cooper (2007) argues the 'headless fatty' (typically

an image of the torso of a large body often from the back, or of larger people eating 'unhealthy food') regularly features in popular culture and media coverage of weight-related issues. The visual representation of larger people in this manner according to Cooper (2007: n.p.), symbolises the dehumanising manner in which larger people are represented in society, "as symbols of cultural fear: the body, the belly, the arse, food". The symbolic decapitation of the person in such imagery according to Cooper (2007: n.p.) suggests:

> It's as though we have been punished for existing, our right to speak has been removed by a prurient gaze, our headless images accompany articles that assume a world without people like us would be a better world altogether.

LeBesco (2004) similarly argues 'fat people' are "viewed […] as unhealthy and unattractive, […] widely represented in popular culture and in interpersonal interactions as revolting - they are agents of abhorrence and disgust" (p.1). Similarly, Leahy (2009) explains that, in relation to large body size, casting doubt on the morality of larger people has helped to facilitate the feeling of disgust commonly expressed in relation to 'fatness'. LeBesco (2011) further argues this framing provides the justification of 'fat bodies' as 'deviant', and therefore, morally questionable. These framings illustrate what several authors describe as a lack of willingness on the part of society to accept body-size diversity (Wray & Deery, 2008; Puhl & Heuer, 2009; McMichael, 2013).

In exploring sociocultural representation of the larger body, Lupton (1995) traces the origins of early epidemics, drawing parallels with the attacks made on the morality of victims of infectious diseases, which at one time were incurable. She explains that forthright assaults on the morality of larger people can be traced back to epidemics such as the Black Death in the 14th Century and the more recent HIV and AIDS epidemics; both of which created fear and moral panic among respective populations (Gilman, 2008). Lupton (1995) explains that Victorian public health discourse, associated with the halt of 19th Century epidemics such as cholera, were heavily influenced by the association of 'cleanliness with Godliness' as a means of influencing the populations' hygiene habits. In commenting on the 'obesity epidemic' Lupton (1995) draws parallels with the moral aspects of Victorian public

health discourse which she sees as prominent in the modern day neoliberal representation of the 'obesity epidemic'. She argues the slim body is culturally represented as a 'healthy body' and a 'good moral citizen', whereas, large bodies are socially read as undisciplined, lazy or ignorant (see also, Teachman & Brownell, 2001; Murray, 2005; Warin & Gunson, 2013), thereby raising questions about individual morality (Throsby, 2007; Lupton, 2012b). Moreover, according to DeMello (2014), in the Western world, obesity has become understood as a condition associated with "laziness, sloth, gluttony and stupidity" so much so that 'fat shaming' is openly tolerated (p.192).

This situation is illuminated by the work of Mary Douglas (1966) who argues that the notion of *purity* is used to create boundaries to Other individual bodies and social groups, with the purpose of maintaining social order through the prevention of contamination. Douglas' (1966) notion of *contamination* and *Othering* has a high level of relevance for thinking about the ways individuals and groups draw boundaries between themselves and Other in relation to marginalised groups. Douglas (1992) further argues that the concept of risk serves as a means to focus of *blame* on an individual or a social group who fail to take responsibility and to be accountable for their actions. Othering serves the purpose of maintaining one's own bodily integrity in the face of the threat from 'risky individuals' or groups. According to Douglas (1992), the concept of risk serves to justify the *condemnation* of 'risky groups' and individuals by attaching blame, as Douglas (1992) says: every accident or misfortune needs to be "chargeable to someone's account" (p.16). Moreover, each culture rests upon its own ideas of what ought to be normal or natural: "If a death is held to be normal, no-one is blamed" (Douglas & Wildavsky, 1982: p.35).

Douglas (1966) suggests that to transgress cultural boundaries creates a stigmatised and contaminated position for an individual: "A polluting person is always in the wrong. He [*sic*] has developed some wrong condition or simply crossed some line which should not have been crossed and this displacement unleashes danger for someone" (p.113). Hartley (2001) suggests that both 'obese' and pregnant bodies transgress boundaries and threaten social order having an uncontained desire for food

and over spilling flesh: “reckless excess, prodigality, indulgence, lack of restraint, violation of order and space, transgression of boundary” (p.3). To culturally transgress boundaries creates a moral difficulty for the person: not only have they infringed cultural norms but they have also created danger for others as a result of their actions. Douglas' (1966) concept of Othering and blame has a degree of resonance with the current criticism which larger women face in maternity settings, and perhaps, helps to understand some of the strength of feelings expressed by MHP towards the bodies of larger women (as discussed in Section 2.8.6). As such, these ideas may be able to illuminate the ways MHP talk about the boundaries between their own bodies and those of the larger women they care for.

3.6.1 Media representation of ‘fat bodies’

In her explication of the ‘headless fatty’ Cooper (2007) suggests that, while larger people have little opportunity for self-representation, in contrast the biomedical and media attention given to the so-called ‘obesity epidemic’ is unprecedented and relentless (see also, Gard & Wright, 2005; Oliver, 2006; Saguy & Almeling, 2008; Lupton, 2013a). Furthermore, scholars argue that the sustained interest in the large body has perpetuated a dominant discourse representing ‘obesity’ as a ‘global catastrophe’ resulting in what is now commonly described in the media as a ‘war on obesity’ (Lupton, 2004; Gard & Wright, 2005; Boero, 2007; Saguy & Almeling, 2008). In critiquing the medical and media representation of the ‘obesity epidemic’ Lupton (2013a) argues that the representation of ‘obesity’ as an ‘epidemic’ and a ‘catastrophe’ is far more concerning than the scale or significance of ‘the problem of obesity’. Furthermore Boero (2007) argues that the media have played a significant role in proliferating mainstream ‘obesity’ discourse, assisting obesity scientists to deliver a moral message about the wrongdoings of larger people, and this has been achieved by dramatising and individualising the ‘problem of obesity’ (Boero, 2012). rendering the ‘obese body’ as highly visible while simultaneously silencing the larger person, rendering them invisible (Tischner, 2013).

The media typically draw on biomedical body-as-machine thinking, depicting ‘obesity’ as preventable (Saguy & Almeling, 2008; Boero, 2012) by drawing on neoliberal medical discourse to frame larger body-size as the sole responsibility of

the individual (e.g. Gard & Wright, 2005; Lupton, 2013a; Saguy, 2013). Typical UK media headlines include: "Obesity bigger cost for Britain than war and terror"[33] (The Guardian, 20th November, 2014). By highlighting the 'burden' 'obese people' place on NHS resources, this type of article constructs larger people as irresponsible, deserving of blame and therefore deserving of castigation. The counter-narrative to this discourse is however given little or no attention, in that the views of those who are critical of the current medical and public health approach to the large body such as the *Health at Every Size* ®[34] (HAES) movement are seldom heard, and accordingly, receive little media attention (Gard & Wright, 2005; Rich & Evans, 2005; Campos *et al.*, 2006; Oliver, 2006; Murray, 2008; Saguy & Almeling, 2008).

Critical weight scholars, including HAES, problematise both the medical and media approach to the 'obesity epidemic' arguing it directly shapes societal attitudes towards larger people and accounts for the upsurge in weight-stigma which is found across the general population (Latner & Stunkard, 2003; Puhl & Heuer, 2009; Lupton, 2013b; Bombak, 2014). Furthermore, recent research examining weight-stigma suggests the moralising undertones associated with the negative cultural stereotypes of 'obesity' are now commonly used to legitimise the widespread discrimination of people labelled as 'obese', affecting many aspects of larger people's lives (Puhl & Brownell, 2001; Brownell *et al.*, 2005).

Several authors also argue that the negative media portrayal of larger people has been drawn on by medicine, as is illustrated by public health campaigns which aim to shame larger people to lose weight by promoting public disgust towards the larger body (Bell, Salmon & Mcnaughton, 2011). For example, England's Public Health Minister Anne Milton was reported by the BBC as encouraging health professionals to use the word 'fat' when talking to larger people, suggesting that doing so was, "more likely to motivate them into losing weight" and, "people should take personal responsibility for their lifestyles" (Triggle, 2010: n.p.). Implicit within the argument

[33] Although often the media talk about the 'war *on* terror', this is the quote used by the newspaper.
[34] The 'Health at Every Size' ® movement advocate body acceptance in the context of recognition that socio-cultural factors affect an individual's ability to control body size. They also recognise that it is possible to be medically classified as 'obese' but also lead a healthy lifestyle (see, http://haescommunity.com/).

drawn on in this narrative is the neoliberal framing of the larger person as failing in their moral duty to maintain a suitably sized body (Lupton, 1995). Perhaps unsurprisingly some authors strongly object to this approach, arguing it represents a form of 'healthism' (Tischner & Malson, 2008), is unethical and emotionally damaging (Puhl & Heuer, 2010; Durso et al., 2012), and may compound weight-related issues associated with eating, guilt and self-esteem (Bacon *et al.*, 2005; Bacon, 2008). Moreover, the emotional effects have the potential to encourage individuals to engage in behaviours leading to disordered eating (Durso *et al.*, 2012), and increased weight-gain (Puhl & Heuer, 2010).

3.6.2 The 'fat female body'

Although both men and women are subjected to social pressure in relation to the cultural norms of body size, Bordo (2003) argues that, due to mechanisms of gender oppression, women's bodies are subjected to higher degrees of internal and external regulation. This, she argues, makes women engage in various bodily modification practices, including the maintenance of a culturally 'acceptable' slim body. Furthermore, Bordo (2003) argues that while men are encouraged to eat heartily women in contrast, are urged to tame their desires, to practice restraint, maintaining their bodies in line with the cultural ideal. In a similar vein, Murray (2008) argues that women's bodies tend to be judged more harshly than men's and are subjected to a higher degree of moralistic assumptions. And indeed, these differences are believed to be strongly influenced by the representation of the 'ideal female body' in women's magazines and other media (Evans & Colls, 2009) along with the intense efforts of the diet industry who tend to focus their advertising on women (Crossley, 2004). In the context of medicine Warin *et al.* (2011) argue that women are also most often targeted in national health campaigns which address weight-reduction. Murray (2008) suggests that, due to the societal criticism larger women receive in comparison with men, women are more likely to view themselves as overweight compared to men and consequently spend more time dieting compared to men.

Scholars also argue that women's bodies tend to be viewed differently from men's due to women's capacity to reproduce (Bordo, 2003). Wolf (1991) suggests this is one of the reasons fatness is most often represented as essentially a female problem.

Women therefore, also receive special attention within anti-obesity discourse due to the cultural expectations associated with motherhood (Murray, 2008; Bell, Mcnaughton & Salmon, 2009; McNaughton, 2011; Warin *et al.*, 2011; Lupton, 2012c). Furthermore, Bordo (2003) argues gender inequalities relating to reproduction have remained problematic despite improvements brought about in the last few decades which address women's rights more generally. And in fact, women's reproduction is highly legally and socially regulated, with women's wishes and rights taking second place to that of the father and the foetus.

In this section I have drawn attention to the inter-relationship of medical and media discourse, which generate negative representations of larger people. I have illuminated that media and medical representations of 'obesity' tend to depict larger people as failing in their duty to constrain the size of their bodies. I have also suggested that public castigation of larger people is achieved through an appeal to morality which aims at evoking a blame and shame approach. In the following sections I focus more specifically on the governance of the female body and the large female body through the concept of risk. Although each section draws on varying theoretical concepts to deal with a different aspect of the governance of the body, notions of morality, blame and responsibility emerge as themes which bind together the final part of this chapter.

3.7 Body politic: risk and the governance of pregnancy

3.7.1 Litigation and defensive practice

UK maternal healthcare policy frames pregnancy and childbirth as a "normal physiological process[es]" (NHS QIS, 2009: p.2). However, Coxon, Scamell and Alaszewski (2012: p.505) suggest that "pregnancy and childbirth have become important sites of risk in late modern societies", whereby clinical governance structures and related risk-management strategies have altered the climate of birth making any degree of risk unacceptable (Donovan, 2006; Scamell, 2015). With the assessment of risk at the centre of pregnancy care, authors suggest physicians and laypeople are encouraged to view pregnancy as a potentially 'dangerous medical condition' rather than a natural embodied state (e.g. Katz Rothman, 1988; Davis-

Floyd, 1990; Donovan, 2006; Lupton, 2012c; Hallgrimsdottir & Benner, 2014). Abenhaim and Benjamin (2011) implicate MHP fear as having an influence on the over-medicalisation of pregnancy, leading to a general increase in the level of intervention and also a tendency to intervene earlier than in previous decades. Therefore, women with 'high-risk pregnancies', including women constructed as 'obese', are likely to be at significant risk of over-medicalisation and risk from iatrogenic complications (see also Sections 2.7.2 and 2.7.3).

The proliferation of risk discourse in maternity settings has been illuminated by several authors, for example, Walsh, El-Nemer and Downe (2004) and Walsh (2007) argue the current perception of risk as controllable or manageable is reflected in the risk management of pregnancy which serves a dual process. Acting firstly, to improve the safety of mothers and babies; and secondly to reduce the cost of litigation to the NHS (Walsh, El-Nemer & Downe, 2004; Walsh, 2007). 60% of all litigation claims made against the NHS arise from maternity services (Scamell, 2014). Concerns about the high cost of litigation has led to a situation whereby all UK NHS Trusts and boards are obliged to evidence the measures they are taking to reduce risks to 'high-risk populations'; currently this includes women who are classified as 'obese' (McGlone & Davis, 2012). The number of medical negligence claims made against the NHS is lower in Scotland compared to England; however, the numbers of claims across the UK have significantly increased over the past few years proportionally (Akien *et al.*, 2001). 70% of all litigation cases brought against the NHS are cases against obstetricians. The majority of these are confined to practices relating to labour wards and 99% of these are due to failure to intervene or delay in intervention (NHS Litigation Authority, 2012).

As discussed in Section 2.4 midwives are responsible for managing referrals to the maternity team. However, Scamell and Alaszewski (2012) suggest that midwives have become more risk averse than previously, and furthermore, they may feel less confident about managing risk due to fear of litigation. Stafford (2001) terms the current midwifery focus on what *might* go wrong as the "what if?" generation of midwives. Although some midwives may feel cautious about managing pregnancies without medical involvement, some are however conscious about the risks incurred

by larger women during pregnancy due to the "cascade of intervention"[35] (Inch, 1989: p.244) (also see Section 2.8.5). And in this respect, midwives have voiced concerns that women may not be fully informed of the risk of early intervention, i.e. having labour induced (Swann & Davies, 2012). It is therefore perhaps understandable that in the current risk averse obstetric culture, the National Childbirth Trust have raised concerns that the over-medicalisation of women's pregnancies has reduced midwives' confidence in supporting women without medical intervention. To this effect, midwives may fail to support women in achieving less medicalised births than previously (Newburn, 2002).

Women are also expected to make decisions in relation to medical interventions during pregnancy. However, Hull *et al.* (2011) and Jordan and Murphy (2009) point out, MHP can heavily influence women's perception of risk by the way they choose to express risk. Qualitative studies have demonstrated that, even in low-risk pregnancies, women's subjective perception of risk is elevated beyond the actual level of risk for their pregnancy (Houghton *et al.*, 2008). This suggests that, where a pregnancy is categorised as 'high-risk', women may perceive the threat to themselves or their baby to be very high indeed.

Dahlen and Homer (2013) suggest the increasing cost of litigation to the NHS and concerns about damage to professional reputation may lead to "litigation–based practice" (p.168) or defensive practice (Johanson, Newburn & Macfarlane, 2002: p.893). Dahlen and Homer (2013) argue that in this respect, it is in the obstetrician's best interests to encourage women to accept "active management" at all stages of pregnancy, especially in cases where complications are anticipated (p.168). Thus leading to a situation whereby women and MHP experience a loss of autonomy, choice and an increase in technico-scientific approaches to childbirth (Scamell & Stewart, 2014).

[35] Swann & Davies (2012) suggest that the increased use of induction in larger women reduces larger women's mobility during labour, and this increases the risk of instrumental delivery and caesarean section. Therefore, induction procedures may be responsible for some of the risks larger women incur in pregnancy.

3.7.2 Social control: risk responsibility and information

Drawing on the sociological writing of Beck (1992), Nettleton (2006) explains that notions of risk and responsibility have been pivotal in maintaining social control which Lupton (2012c) describes as risk consciousness. In relation to the maintenance of 'good health', the 'good citizen' is one who engages self-reflexively with health promotion and health education information, reducing risk to self and others (Mol, 2008). Beck's (1992) writing on risk society helps to illuminate the central role risk and information have in the context of pregnancy, and to this effect, Lupton (1993, 1999a) argues that, in contemporary societies, women are expected to engage with an ever increasing range of information and related risk avoidance behaviours in pregnancy. Such actions are designed to protect the developing foetus in a society which is generally more risk averse, as people seek to gain more control over their lives.

In the context of 'maternal obesity' women are faced with a high level of information about the perceived risks associated with embodied largeness during pregnancy (CMACE/RCOG, 2010), which are related to the additional screening larger women are offered and the variety of informed decisions women must make over the course of their pregnancy. I found Beck's (1992) concept of *individualisation* (a constitute of his theories about risk society), helps to explain the impact of the overburdening of responsibility which women have reported during pregnancy (Ruhl, 1999). Helping to shed light on the ways women are currently positioned as singularly responsible for the welfare of the foetus (Bell, Mcnaughton & Salmon, 2009; McNaughton, 2011; Lupton, 2012c, 2013c).

The notion of informed consent is a prominent and guiding aspect of healthcare practice. Informed consent is based on the idea that health professionals work in partnership with patients to provide information, and to enter into discussion about the patient's condition and treatment options with the aim of supporting them in making a decision about health interventions (General Medical Council, 2008). However, Ruhl (1999) argues the choices pregnant women make are not actually free choices, but are "highly circumscribed by a language of risk" (p.104), and may lead towards what Bassett, Iyer and Kazanjian (2000) term, 'risk compliance'. Risk

compliance describes situations whereby patients are guided to make the decision the healthcare professional desires. In this situation it is the manner in which risk is communicated which influences the patients' decisions. In the context of MHC several authors point out that physicians may heavily influence pregnant women's perception of risk (e.g. Alaszewski & Horlick-Jones, 2003; Jordan and Murphy, 2009; Hull *et al.*, 2011). Jordan and Murphy (2009) provide this example of how the same risk is altered by the way it is expressed e.g., choosing the perspective of *relative risk* (i.e. your risk is 37 times higher) makes the risk of this complication occurring sound more likely than when expressed in absolute terms (e.g. your risk is 0.2%).

Furthermore, qualitative studies have demonstrated that, even in low-risk pregnancies, women's subjective perception of risk is elevated beyond the actual level of risk for their pregnancy (Houghton *et al.*, 2008). This suggests that, where a pregnancy is categorised 'high-risk', women may perceive the threat to themselves or their baby to be very high indeed. There is some evidence to suggest risk-compliance occurs in maternity settings as is exemplified by O'Cathain *et al.* (2002) who studied the perception of a large group of pregnant women to ascertain how they made informed choices. These authors found that women understood informed choice as being advised by the HCP of the course of action which the HCP feels is advisable, rather than having all options explained. It seems likely that if pregnant women feel they are at 'high-risk of complications' then they may also be vulnerable to risk compliance rather than informed choice (Dahl *et al.*, 2006).

As women are expected to make decisions for the wellbeing of the foetus in pregnancy, some authors suggest pregnancy creates a unique moral position for women. For example, Murphy (1999) suggests, pregnancy potentially places women in 'moral jeopardy' in the context of the development of a highly risk-aware and risk-averse culture. Compliance with pregnancy advice is, therefore, best considered as a moral issue (Bessett, 2010). Furthermore, although individuals are free to deviate from pregnancy health guidance, by doing so they risk becoming classified as a 'bad patient' (Kelly & May, 1982; Murcott, 1981, cited by Bessett, 2010). Under these circumstances it seems highly likely that feelings of guilt, shame and self-

blame may be associated with any perceived deviance from health guidelines. In the following section I extend this discussion exploring the way obstetric technologies act in relation to pregnancy management, illuminating how notions of risk, blame and responsibility are implicated in the social and medical control of women during pregnancy.

3.8 The production of the 'good mother'

3.8.1 Risk, technology and the 'vulnerable foetal body'

As a result of the technological context of modern pregnancy care, authors argue that women may prefer to avoid birthing technology in favour of more 'natural' approaches to childbirth (e.g. Edwards, 2005). Whereas conversely, others say they gain more control during labour by choosing medical technologies to, for example, control pain by epidural anaesthetic or by choosing a caesarean birth (e.g. Davis-Floyd, 1990, 1994; Callister, 2004; Bryant *et al.*, 2007; Wendland, 2007). Zinn (2008) suggests that when individuals feel at risk they seek to develop trusting relationships with institutions as a means to feel safer. The implication of this situation is that women encounter increased contact with obstetric technologies which are associated with iatrogenic complications; however women may ignore or be unaware of the risks associated with such technologies (Coxon, Sandall & Fulop, 2014). Furthermore, these authors suggest women may choose higher levels of medicalisation out of fear of being seen as irresponsible for not seeking to provide a safe birthing environment for themselves and their unborn child. Similarly, Ruhl (1999), drawing on the writing of Rose (1993) and Valverde (1996) on governance, argues: "the liberal governance of pregnancy mobilizes a discourse of risk, and risk prevention and reduction, that enlists the co-operation of the 'responsible' pregnant woman" (p.95). Therefore, it is not just the physical aspects of childbirth that concern women, and women may deliberately seek the safety of modern technological obstetric care to mitigate being cast as morally unfit mothers who fail to take responsibility for their unborn child (Hallgrimsdottir & Benner, 2014; Scamell, 2014).

The central role risk has in relation to social control in pregnancy can also be viewed through Foucault's (1973, 1991, 1995) interrelated concepts of biopolitics and

governmentality which, he argues, are a feature of modern neoliberal societies. The Foucauldian lens of biopower (Foucault, 1995) provides an important means to understand the ways discourses of risk act on women in pregnancy, explaining the ways women become implicated in their own oppression. In relation to risk management, Foucault's (1995) notion of the 'docile body' helps to reveal the ways that the population seeks to minimise the risks they are exposed to through voluntary self-surveillance and self-discipline. Ruhl (1999) argues: "Risk discourses depend on the entrenchment of a sense of personal responsibility which is downplayed and even lost if activities are simply forbidden" (p.96). In doing so she draws attention to the docile body as a 'responsible and willing body'. Like Beck (1992) who emphasises individualisation, Foucault's (1978) concept of biopower also enacts the ways individuals take up risk discourse and act on their own bodies.

Several authors explore the governance of women's bodies drawing on Foucault's (1978) lenses of biopower/biopolitics and governmentality. Ettore (2002) for example, examines surveillance medicine, and argues the increased critical attention from both 'expert' and the general public, and the intensity of advice given to pregnant women in recent years represents nothing short of "reproductive asceticism" (p.246), meaning that women are highly compelled to stringently monitor and control their bodies to benefit the wellbeing of their unborn child. Meanwhile, Longhurst (2005b) argues that women's bodies are highly publicly scrutinised. Furthermore, she suggests that, although first-time mothers may welcome the attention and advice, they are offered by MHP, friends, family (and often complete strangers), there is also a darker side to the societal interest shown to pregnant woman. In fact, she argues that women also find they are more likely to have their behaviours scrutinised, and to be judged negatively when they fail to behave 'appropriately'. Longhurst (2005b) terms this phenomenon "societal supervision" (p.87), arguing women become public property as soon as the pregnancy is confirmed.

Meanwhile, Bordo (2003) terms the extreme levels of vigilance over their self-care which women are expected to take during pregnancy "supererogatory" (p.83). Lupton (2011) argues that, in this respect: "Mothers and pregnant women […] are at

the centre of a web of expert and lay discourses concerning the ways they should promote and protect the health and development of their foetuses and infants" (p.637). A feature of such discourse is the construction of pregnant women as responsible for making the 'correct' choices to protect the foetus, which is achieved through a medico-moral discourse, i.e. the 'good mother' (Bell, McNaughton & Salmon, 2009), and the association of blame where women are perceived not to be acting in the interests of their unborn child (e.g. Possamai-Inesedy, 2005; Gross, 2010; Warin *et al.*, 2012; Coxon, Sandall & Fulop, 2014; Katz Rothman, 2014).

Foucault's (1978) concept of biopolitics helps to illuminate the way health is conceptualised as a condition that all individuals should 'choose' through the careful following of 'expert' guidelines, and by adopting a lifestyle which avoids risk (Lupton, 1995). However, the Foucauldian notion of the construction of self which is a product of knowledge/power has been criticised for failing to account for the ways people resist and counter-discourse (Lash, 1991). Several authors, therefore, have engaged with discussions about how individuals resist the totalising effects of dominant discourse (e.g. Deleuze & Guattari, 1984; Butler, 1990).

3.8.2 Permeable bodies

Nested within the sociological literature on risk in pregnancy is writing about maternal/foetal conflict. This literature sheds further light on the ways risk, responsibility and blame are woven into pregnancy risk discourse. For example, Martin (1989) argues that mothers who fail to privilege foetal wellbeing are likely to be constructed as selfish mothers. Likewise, Ruhl (1999), Duden (1993) and McPhail *et al.* (2016) suggest that, in considering the role of risk in pregnancy, the primary concern is not risk to the mother from the pregnancy, but rather it is the *foetus* who is perceived as being at risk *from* the mother, or more precisely the mother's actions. This writing suggests that the maternal body is now viewed as in *opposition* to the foetal body (Katz Rothman, 1989; Lupton, 2012a, 2012c, 2013c).

The use of modern ultrasound technology has been implicated in the shifting status of the foetus, privileging its wellbeing over that of the mother, creating additional responsibilities for women and a discourse of mother blame. This literature extends

my thinking *with* the body (Scheper-Hughes & Lock, 1987): linking the once private world of the foetus with social discourse of maternal responsibility.

According to Harrison:

> The fetus [sic] could not be taken seriously as long as he [*sic*] remained a medical recluse in an opaque womb […] the prying eye of the ultrasonogram […] rendered the once opaque womb transparent, stripping the veil of mystery from the dark inner sanctum, and letting the light of scientific observation fall on the shy and secretive fetus (Harrison, 1982, cited by Bordo, 2003: p.85).

Harrison (1982) suggests that, although sonography has brought about improvement to the care of the foetus by allowing medical access and treatment prior to birth, the use of this technology has also brought about changes in the way society thinks about the foetus. One significant change brought about through the advancement of foetal medicine is that this technology has assisted in establishing foetal viability and personhood earlier in pregnancy than was previously possible, helping to establish the foetus as a person and a patient (Markens, Browner & Press, 1997). Foetal sonography has, therefore, helped in establishing the foetus as a separate legal being (Franklin, 1987). Furthermore, Bordo (2003) suggests, the foetus has taken on the position of a "super-subject" (p.80), as is seen in situations whereby the foetus is privileged over the mother, i.e. the legal enforcement of medical interventions, such as caesarean sections, against the mother's wishes.

Several authors have drawn attention to the imagery which is evoked by the uses of foetal sonography, pointing out that this technology provides the means to imagine the foetus as 'captive' in the womb (e.g. Bordo, 2003; Palmer, 2009; Lupton, 2012a, 2012b, 2013c). On that note, Bordo (2003) argues that technological developments have helped to create a culture where the mother's womb is viewed as both incubator and captor: "The viable unborn child is literally captive within the mother's body" (p.85). These authors argue the consequence of such thinking is to increase the responsibility women feel in relation to foetal wellbeing. Some authors argue that societal discourse suggests the foetus has become fetishised (Lupton, 2012c; Warin *et al.*, 2012).

In addition to viewing the foetus as 'captive', Lupton (2012a, 2012b, 2013c) suggests the use of ultrasound technologies allows the medical gaze to routinely penetrate both maternal and foetal bodies, and has brought about a situation whereby both the foetal and maternal bodies are constructed as highly permeable. Lupton argues that framing the foetal body as permeable emphasises its fragility, intensifying concerns of foetal vulnerability in the context of maternal behaviour (see also Chapter 2 for the discussion on Barker's hypothesis and 'maternal obesity'). Warin *et al.* (2012) argue that women have long been positioned as potential corrupters of the foetus through the intake of food and drink and strong emotions which may result in damage to the foetus. These ideas have a long history dating back to times when it was believed disabilities were caused by strong maternal emotions or sexual deviance during pregnancy. Further, the authors argue, pregnant women's appetites are also viewed as potentially harmful to the foetus and therefore, require curtailing in order to protect the foetus from harm. This writing draws attention to the maternal body as representing a potential danger to foetal wellbeing. Therefore, ultrasound technology has created a situation whereby the medical gaze seeks to address foetal vulnerability through the governance of pregnancy (Lupton, 2012a, 2012b, 2013c).

The positioning of foetus as 'captive' has a particular resonance with a body of feminist literature that discusses the notion of mother blame in relation to the larger pregnant body. The concept of mother blame, once used to keep women in the home by positioning women who worked outside the home as 'bad mothers', has now extended to colonise the womb (Pollitt, 1998). Feminist critics draw attention to the gender biases which are inherent within neoliberal societies (e.g. Weir, 1996; Lupton, 1999b; Ruhl, 1999; Marshall & Woollett, 2000; Root & Browner, 2001; Bordo, 2003; Weir, 2006; Harper & Rail, 2012; Thomas & Lupton, 2015). This work provides a particular symbolism for the ways women and larger women's lifestyle choices are morally positioned in opposition to the foetus: describing what Bordo (2003) would call the upsurge of the 'foetal super-subject'. The notion of the 'foetus as super-subject' (Bordo, 2003), the discourse of mother-blame (Pollitt, 1998), and the idea that maternal and foetal bodies are permeable, and therefore vulnerable (Lupton, 2012a, 2013c) seem to have significance in relation to thinking *with* the

large pregnant body (Scheper-Hughes & Lock, 1987), providing a way to think about how modern technologies and societal discourse act on the larger pregnant body.

3.9 Conclusion

In this chapter I discussed a philosophical approach to understanding how the 'fat body' and pregnant body are viewed and understood using medical, social and cultural lenses. I drew on the writing of Scheper-Hughes and Lock (1987) and Jones (2011) to think *with* the body. Doing so enabled me to identify the philosophical origins and tensions within approaches to the body. As these authors suggest, the social and material body, although philosophically opposed, can be somewhat reconciled by thinking *with* the body rather than *about* the body. 'Body as specimen' and 'body as spectacle' suggest an approach to analysing the way the larger body is understood in the context of MHC. Meanwhile, Jones' (2011) notion of the 'body as patient' I suggest provides a potential methodological approach to studying pregnant embodiment.

Each of the theories I have discussed in this chapter deals with the concepts of social control, surveillance and governance of the body, explicating the ways individuals are urged to take responsibility for managing risks to self and also in participating in the governance of others. The neoliberal imperative urging citizens to take responsible action also resonates with the medico-moral imperative governing the 'fat body' which helps to explicate how 'fat bodies' become stigmatised. Mary Douglas' (1966) concept of Othering and blame demonstrates how boundaries are maintained; providing a novel way to also think about the 'fat body' as a potentially 'infectious body'.

Furthermore, the theoretical approaches I have discussed all help to sensitise thinking in relation to the political governance of the body, again providing a way of thinking *with* the body and as a means to frame analysis. It is evident from the literature informing this chapter that the large body, and in particular the large female body, are problematised by a variety of stigmatising discourses and associated with notions of responsibility and mother blame. Particularly relevant to the analysis of the management of larger women's pregnancies are new technologies (especially those

which visualise the foetal body) and I am particularly interested in the notion of the foetal body as permeable.

What seems clear from examining the concept of risk through the lens of biopower is that women and MHP are likely to take up various positions to account for the ways they engage with the notion of risk, responsibility, and blame in the context of maternal healthcare and pregnant embodiment. Moral talk is therefore likely to be found in the narratives of women and MHP. Therefore, examining the ways protagonists position themselves in the stories they tell, has promise for exploring the ways risk discourse is drawn on in maternal healthcare spaces as a means of exploring how ‘high-risk pregnancy’ is experienced by women.

Chapter 4 Methodology

4.1 Part 1: conceptualising and studying experience

I have committed to studying larger women's experience of pregnancy drawing on an adaptation of Jones' (2011) theoretical framework to think about the body. In this chapter I take forward Jones' (2011) notion of 'body as patient', which Good (1994) asserts is best understood through the stories individuals tell about their experience as patients. The chapter is divided into 2 parts. In Part 1, I consider stories as a means for conceptualising, exploring and understanding 'body as patient'. Part 2 deals with ethical research design.

4.2 'Body as specimen' and 'as patient'

It is suggested that biomedical knowledge, generated by the successful eradication of various diseases, claims to have the only feasible approach to understanding health and illness through 'objective science' (Kalitzkus & Matthiessen, 2009). Freidson (1970) argues that as a result of these successes, the medical profession now holds the revered societal position once held by religion. However, the history of medicine is selective about which stories are told, in that biomedical discourse tends to raise up successes and bury failures.

According to Greenhalgh, Hurwitz and Skultans (2004), the type of narrative research which focuses on the stories patients, caregivers and practitioners tell about experiences of health, illness, and caregiving, emerged within the field of medicine as an attempt to repair the relationships between doctors and patients following moral outrage caused by poor ethical practices in medical research during the 20th Century. More recently, the concept of 'evidence-based medicine' (EBM), often referred to as the 'holy grail' of biomedical knowledge (Howick, 2014) (which I discussed as forming the basis of the medical care of larger pregnant women in Chapter 2), has come under criticism, prompting a renewed interest in patients' narratives (Greenhalgh & Hurwitz, 1999). Much of the criticism of EBM points to its focus on medicalisation which relies on knowledge generated via positivist over interpretivist epistemologies (see Sections 2.2 & 2.3). Therefore it is argued that EBM neglects patient experience, and patient and practitioner propositional

knowledge (e.g. French, 1999). What is now referred to as 'narrative-based medicine' has grown from the desire to generate patient and practitioner propositional knowledge as a complementary form of knowledge to EBM.

One strand of narrative research in medical settings examines "the unfolding and interwoven story between healthcare professionals and patients" (Kalitzkus & Matthiessen, 2009: p.80), brought about by the acts of providing and receiving healthcare (Greenhalgh, 1998). In relation to exploring larger women's experience of pregnancy, especially in light of the 'thorny issues' I discussed in Sections 2.8 and 2.9, I suggest that exploring the interwoven narratives of larger women and MHP offers a means to explore 'body as specimen, spectacle and patient' (Jones, 2011), or as Squire, Andrews and Tamboukou (2008) put it: "bringing them into useful dialogue" (p.1).

4.3 Experience and the construction of reality

The social constructionist position argues that our experiences, or in other words, our 'reality' is socially constructed through language (Berger & Luckmann, 1967). Reality, therefore, is not 'out there' waiting to be discovered but is a product of the way we categorise the world (Burr, 1995). It is through our thoughts therefore, that lived experience becomes 'objective'. As Gergen (1985) puts this "what we take to be experience of the world does not in itself dictate the terms in which the world is understood" (p.266). Instead we must consider, our *representations* of the world and these are formed by discourse. Accordingly, Burr (1995) suggests that language has an "important role in human life […] the very nature of ourselves as people, our thoughts, feelings and experiences, are all the result of language" (p.33). Therefore, what we call experience is not possible without language. We cannot therefore claim that we can study 'raw' experience as it does not exist separately from the language used to describe it; experience is always contextualised and inherently discursive (Maynard & Purvis, 1994).

Gee (1999) argues that the mechanism we use to construct versions of reality and make sense of experience is discourse. He goes on to say that human beings are "carriers" of discourse, in that we "represent and enact" discourse in the context of

our lives (1999: p.18). Discourse, in this way, represents what Gee (1999) describes as long-running conversations. Using the metaphor of 'dance', Gee (1999) says discourse "exists in the abstract as a coordinated pattern of words, deeds, values, beliefs, symbols, tools, objects, times, and places and in the here and now as a performance that is recognizable as just such a coordination" (p.19). The discourse of maternal obesity therefore, can be understood using Gee's (1999) metaphor of 'dance' as consisting of the coordinated pattern of ideas depicting, for example: the 'normal pregnant body'; the 'abnormal pregnant body'; the values relating to morality and pregnancy; objects with symbolic meaning relating to healthcare and the pregnant body; 'accepted practice' relating to the care of women; and related healthcare policies.

Gee (1999) also suggests that we are involved in both the creation, and recognition of discourse, through an on-going reflexive process. As discourses are generated by people, they are always evolving and changing allowing us to recognise and "understand [our] own and others' thoughts, language, action, and interaction" (p.23). Discourses are "material realities" in that they are out there "in the world […] as coordinations […] of people, places, times, actions, interactions, verbal and non-verbal expression, symbols, things, tools, and technologies that betoken certain identities and associated activities" (Gee, 1999: p.23). Therefore, discourses are present in the "work we do to get people and things recognized in certain ways and not others, and they exist as maps that constitute our understandings" Gee (1999: p.23). Discourses of maternal obesity therefore are actively involved in getting larger pregnant women recognised in particular ways.

Gee's (1999) notion of discourse as 'dance', and human beings as carriers of discourse highlights the reflexive nature of human beings in relation to sensemaking, and the continual evolving and changing nature of discourse. This conceptualisation suggests that the events making up our lives are open to various interpretations which we make by drawing on discourse as a resource, highlighting the somewhat messy nature of what is considered 'reality' in the social world.

4.3.1 Organising experience: sensemaking

Having set out an argument in the previous section that experience is best viewed as socially constructed through language, and the product of various versions of 'truth' contained within sociocultural discourse, in this section I discuss how individuals construct stories to help them make sense of experience. To do so I will draw on Ricoeur's (1991) writing on narrative identity, which explicates the individual reconfiguration of dispersed and fragmented events across time as the basis of my conceptual understanding of how individuals structure experience in relation to social context.

Ricoeur (1984) draws on a teleological principle, suggesting that we are predisposed to reconfigure the fragmented events and happenings in our lives in a way that these events make sense to us. Following this thinking, Ricoeur (1991) argues that the past, present, and expected future are woven together through our lives forming a *narrative identity* in which fragmented events and happenings come together in our thoughts, feelings and actions.

Ricoeur's (1984) ideas rest on Aristotle's concept of *muthos* (the Greek word for plot or narrative emplotment), which he uses to argue that stories of personal experience originate from our pre-understandings of the events and happenings in our lives. Human experience in this pre-narrative state is a "prefiguration" (Dowling, 2011: p.3) of individual consciousness in the context of cultural discourse. Our lives are made up of many interconnected fragments of experience across time and place. Therefore, we need to make sense of the things that happen to us, and consequently, we organise them into stories which are capable of answering the questions: "what", "why", "who", "how", "with whom", or "against whom" in regard to any action" (Dowling, 2011: p.55).

The plot therefore is central to the purpose of the stories we tell about our lives, revealing how we understand our experiences and the way that we want to be known. In this sense we are "tangled up in stories" (Ricoeur, 1991: p.30) which weave through our lives. These stories are the "pre-history of the story" (Ricoeur, 1984: p.75) and provide the background from which narrators' stories are selected.

"[B]eing-entangled in stories" (Ricoeur, 1991: p.30) means that some stories are not selected from the background, but they re-inform the broader narratives of our lives.

Ricoeur's writing on narrative identity seems to suggest that, by paying particular attention to *why* individuals tell certain stories at a particular point in time, more can be understood about how people construct their experiences in a way that makes sense to them. Meanwhile, Gee's (1999) conceptualisation of how discourses *act* points towards a means for exploring how, both larger pregnant women and MHP position themselves, within the 'dance of maternal obesity'; revealing the discourses they draw on in sense making. Furthermore, I suggest that exploration of both larger women's and MHP stories may provide a means to investigate the way that larger women's and MHP narratives are interwoven, thus illuminating larger women's experience of MHC, revealing more about how these experiences shape pregnant embodiment.

4.4 Part 2: research design and ethical considerations

In this part of Chapter 4 I describe the research design I used to generate storied data. Connelly and Clandinin (2006, cited by Kim, 2016: p.90) suggest that narrative research involves "an act of imagination" in which it is necessary to imagine the research field and the participants' lives and experiences as a starting point for designing a study. I found this a useful way of approaching designing as imagining the participants' lives involved attending carefully to the ethical considerations relating to this research.

4.4.1 Research advisory group

In previous chapters I highlighted that larger people represent a highly stigmatised societal group (Puhl & Heuer, 2009), who may be reluctant to engage with health services (Furber & McGowan, 2011). This does seem to suggest that one of the reasons for the lack of good quality research exploring larger women's experience of maternal healthcare may be partly due to difficulties with involving larger women in research (e.g. Warin & Gunson, 2013). Shaghaghi, Bhopal and Sheikh (2011) propose that lack of knowledge or cultural sensitivity to the practices, concerns, or

feelings of populations existing outwith dominant culture make it more difficult to involve people in research. According to *Involve*, the practice of involving individuals with first-hand experience of a phenomenon in the early stages of research has a range of benefits. These include, the identification and prioritisation of research topics, assistance with participant recruitment, and sensitising researchers to the cultural milieu of communities where the researcher and research practices may be perceived as unfamiliar, irrelevant or even threatening (Hayes, Buckland & Tarpey, 2012). In response to these considerations I formed a RAG who contributed to the design of the research, helping to formulate a recruitment strategy, participant information materials and interview guides. Full details of the group members and the contributions they made can be found in Appendix 1.

4.5 The research design

Wishing to explore how women experienced pregnancy in the context of MHC, I opted for a repeat interview study which I imagined would allow me to explore discursively the *on-going* experience of pregnancy, examining how women made sense of their interactions with the context of MHC. My decision was influenced by Coxon, Sandall and Fulop's (2014) suggestion that interviews conducted after childbirth may not provide a contemporaneous account of the experience of pregnancy, as this approach can only capture sensemaking after the event. Also, McLeod (2000) notes that repeat interview studies can "illuminate, confirm or unsettle initial and tentative interpretations, alert us to recurring motifs and tropes […] as well as shifts and changes" in individual narratives (p.49). I ruled out a single interview study on the grounds that, although they have been shown to be useful in examining the experience of pregnancy at a particular point in time (a snapshot), or a means to understand how women make sense of pregnancy and childbirth (retrospective), these types of studies are potentially unable to capture the complexities of the on-going embodied experience of pregnancy as it unfolds over time.

A repeat interview design presented a suitable option for answering the research question: how do larger women experience pregnancy, childbirth and maternal healthcare in the context of 'maternal obesity'? In relation to considering how best to

explore the context of MHC, answering the following sub questions: how do MHP frame and represent the larger women they care for? And, what do these framings reveal about the context in which larger women experience maternal healthcare? I felt that a single interview with MHP who had the most contact with larger women would suffice.

4.5.1 The research site

According to Bechhofer and Paterson (2000) decisions about where to conduct research and who to study are of fundamental importance to research design; however, the process of these decisions, "depends largely on the imagination, ingenuity and capacity for lateral thinking rather than the straightforward application of scientific principle" (p.43). As I wished to study pregnancy in the context of maternal healthcare it was both methodologically and practically beneficial to study a single context, or research site. The thinking behind this aspect of the design was that, in doing so, the research field would be constitutive of the same healthcare professionals, policies and associated practices. I selected a maternity hospital where I already had identified a NHS gatekeeper who would be able to assist in accessing the research site and recruiting participants.

4.5.2 Sample

Pregnant women

In this section I set out how I decided who to include in the research sample. Collingridge and Gantt (2008) suggest that selecting participants in qualitative research is directly related to the research question(s). Sampling is therefore a key factor in relation to successful research (Johnson & Rowlands, 2012). Decisions about sampling strategies should also be guided by the study's epistemological framework (Curtis *et al.*, 2000). Sampling involves thinking about not only who is studied, but should also consider the type of phenomena to be studied, the time frame, and type of event or incident (Holloway & Freshwater, 2007). Bearing these points in mind, I recognised that I needed to make decisions about who to include in the study, how many participants to include, and *what* I was sampling in relation to the event.

In considering *'what'* to sample, I was aware from the healthcare literature that many larger women considered themselves to be healthy prior to pregnancy, and therefore, were perhaps unlikely to be aware of the 'high-risk' status their pregnancy would attract (Furness *et al.*, 2011; Schmied *et al.*, 2011). Bearing this in mind, I chose to study pregnant women with no health issues which were likely to complicate their pregnancies. Adopting this strategy meant that the pregnancy would be classified as 'high-risk' by virtue of the women's weight status. Therefore, I would be able to investigate the experience of *becoming* classified as a 'high-risk' pregnancy.

Literature suggests that women become more confident in subsequent pregnancies (e.g. Corbin, 1987). This makes the experience of first pregnancy somewhat unique. Subsequent pregnancies are likely to be experienced differently because women draw on their previous experiences to frame the current pregnancy. Therefore, the ways that women engage with aspects of maternal healthcare is markedly different in subsequent pregnancies (Simmons & Goldberg, 2011). Bearing this in mind, I felt that it was important to involve women experiencing their first pregnancy[36].

Sampling decisions were also influenced by considering which women were most likely to possess detailed information relating to the experience of pregnancy and healthcare as a larger woman i.e. purposive sampling (Mason, 2002). I made this decision based on *Pathways for maternity care* (NHS QIS, 2009), which recommends that all women with BMI $\geq$35kg/m^2 are referred to the maternity team for assessment. Therefore, this group of women undergo a range of obstetric assessments suggesting that women with BMI $\geq$35kg/m^2 represent the most suitable sample group for the study. For ethical reasons I also excluded participants who were under 16 years of age, which is under the age of consent for sexual intercourse in the UK.

MHP

Having discussed the context of MHC as discursive, I imagined that studying the context of MHC would involve interviews with MHP who were directly involved in the clinical care of women. These professionals would be able to talk in detail about

[36] I included women who had experienced an early miscarriage before 12 weeks of pregnancy.

their experiences of providing MHC. Based on the *Pathways for maternity care* (NHS QIS, 2009) and the CMACE/RCOG (2010) *Joint Guideline: Management of Women with Obesity in Pregnancy*, these MHP are midwives and obstetricians. Midwives have contact with women in community and hospital settings, therefore, in order that a full range of midwives were included I aimed to sample from each of these contexts. Obstetricians[37] have various levels of formally recognised experience, so I aimed to include consultant obstetricians along with less experienced obstetricians.

4.5.3 Sample size

In qualitative research, the number of participants included in a study depends on the methods chosen for analysis and the type of study. In studies, where the aim is to generate themes across the research data, 6 to 12 participants may be an appropriate number, providing there is 'thematic redundancy' after analysing 6 participant's data (Beitin, 2012). Sandelowski (1995) suggests that having too many participants is likely to result in data which is very superficial, or impossible to analyse in depth. Meanwhile Kvale (1996) suggests that, in interview research, around 10 to 15 participants are usually required depending on the type of study.

Holloway and Freshwater (2007) suggest that, when using narrative methodologies, lower numbers of participants are required, as data collection methods involve the generation of information-rich data. Furthermore, Kvale (1996) suggests that, as narrative research aims to generate depth, the number of participants required to answer the research question(s) may also depend on how participants engage with the interview. O'Reilly and Parker (2012) echo Kvale's (1996) point, suggesting that, rather than focussing on the number of participants, researchers should concern themselves with the *quality* of the data. Therefore, as Kim (2016) points out it is more appropriate to consider the suitability of the data in terms of answering the

[37] According to the General Medical Council (2018), initial medical training takes place over a period of 6 years. This is followed by a further 2 year foundation training programme (referred to as FY1 & FY2) before going on to undertake 'specialty' training lasting for 7 years (ST1-ST6). On completion of this training doctors are eligible to apply to become a consultant.

research questions, rather than just the numbers of participants, and this requires a flexible approach to sample size.

In light of this thinking I planned to sample the experience of a minimum of 6 pregnant women, 8 midwives and 2 obstetricians. At the time I felt that these were the MHP who had most contact with larger pregnant women. However, decisions about when to stop recruiting were not taken until I had committed to a method of analysis. The decision to stop recruiting was also made after some of the interviews had been completed and the data transcribed. At this point I was able to visualise the depth of the data from these interviews. As data collection progressed, I increased the sample size of the obstetricians from 2 to 6 when I realised the nature of the contact women had with obstetricians was more significant than I originally anticipated. Furthermore, when it became apparent that the brief contact women with BMI $\geq$40kg/m^2 had with anaesthetists during their pregnancy was important, I also recruited 2 anaesthetists to the sample.

4.6 Studying pregnancy: repeat interview design issues

As research interview studies involve considering temporality, decisions have to be made about when to begin and end data collection, and also how frequently to collect data. In this respect I felt I could time the interviews to coincide with points in the pregnancy whereby women were likely to have increased levels of contact with the healthcare context according to *Pathways for Maternity Care* (NHS QIS, 2009). Ultimately, in terms of study design, the current research demonstrates the complex relationship between how best to study pregnancy and what is ethically feasible. The time-bounded nature of pregnancy makes identifying the beginning and end of the physical embodied aspect of pregnancy easily identifiable; helping in imagining how best to 'sample' the experience of pregnancy for the purposes of designing research. For many women, the 'experience of pregnancy' begins the moment the pregnancy is confirmed by a pregnancy test, although 'suspecting pregnancy' may also later become part of the pregnancy experience (Ross, 2018). Although it may be desirable to begin a study of pregnancy as early in the pregnancy as possible, there are some

important ethical considerations which may make this more complex. I discuss these in the next section.

4.7 Imagining ethical research

As I view ethical research practice as an integral aspect of research design, in designing this research I foregrounded ethical considerations. My view of the practice of ethics is based on the premise that social research requires a personal and moral relationship with participants (British Sociological Society, 2017). Ethical practice is best regarded as an *on-going process,* rather than a static set of rules (Franklin *et al.*, 2012; Pollock, 2012). In this section I draw attention to how my personal biography shaped the decisions I made about the research design.

Although my research practice is not linked to, or governed by, my professional status as a nurse and a counselling lecturer, I am morally guided by professional ethical codes of practice relating to nursing (Nursing and Midwifery Council, 2015), and counselling (British Association for Counselling and Psychotherapy, 2013). However, my ethical position in relation to research practice is strongly influenced by my counselling background, and in particular person-centred theory (Rogers, 1951). This approach highlights the role of empathy, unconditional positive regard and congruence[38] in respectful relationships. As a person-centred counsellor I realise I am likely to respond to research participants in ways which reflect my counselling background. My approach to ethical practice has also been very much influenced by feminist writers (e.g. Oakley, 1981; Harding, 1991; Reinharz, 1992; Stanley & Wise, 1993). These authors argue that the power differentials, which are often present within research relationships, require careful attention at the research design stage.

Ethical approval for this research was sought and granted by the university and local NHS Research Ethics Committee. My discussion in this section relates to the moral principles I drew on to inform the design of the research. As I have already indicated, I view ethical considerations as an on-going aspect of the research process. I also understand ethics as inextricably entwined with reflexivity in relation to participant

[38] Rogers (1951) suggests that these core conditions are necessary for meaningful interpersonal relationships in which individuals can self-actualise.

and researcher wellbeing and the integrity of the research (Guillemin & Gillam, 2004). Therefore, I understand that being an ethical researcher means acknowledging that ethical practice requires an on-going reflexive engagement at all stages of the research process. Finlay (2002) suggests on-going careful attention to reflexivity increases trustworthiness and integrity of qualitative research. Following Finlay's (2002) argument I have made more transparent my positionality in relation to the decisions I have made in conducting this research so that the reader can evaluate how my subjectivity has shaped the research process.

Wiles *et al.* (2007) suggests that researchers take either a rights or moral based approach to engaging reflexively with research ethics. In Chapter 3 I indicated that pregnancy may place larger women in 'moral jeopardy' (Murphy, 1999). Therefore, I have taken a moral based approach to the research design as this best fits with my ethical views in relation to marginalized groups of people. Moral based approaches rely on the application of moral principles as a guide for reviewing ethical issues. Wiles *et al.* (2007: p.7) identify four main principles which are most commonly referred to in approaches to research ethics:

- Autonomy: people must be free to make their own informed decisions about participation in research
- Non-maleficence: research must not inflict harm
- Beneficence: research should benefit others
- Justice: people must be treated equally within the research process

The ethical principles of beneficence and justice are applied in conducting research which can demonstrate benefits to society. In the case of the current study these principles were met by designing research addressing a social injustice in terms of the societal treatment of larger women. Although the study may not directly benefit participants[39], generating knowledge about the experiences of larger women represents a step towards equal social validity for a marginalised group of society.

[39] Some writers suggest that there are benefits for participants in having the opportunity to talk at length about their lives has a therapeutic benefit for participants.

Therefore, the current study demonstrates the principle of beneficence in that the research will benefit others.

Having said that ethical considerations influence all aspects of the research process, I have woven ethical discussions throughout the thesis at various junctures; however, a summary of these are presented in Table 4.1. I will discuss further these aspects of the research in relevant sections as indicated.

Table 4.1 Ethical issues

Ethical concern	**Moral principle**	**Mitigation**
Recruiting larger women - larger women may have had previous negative experiences due to their weight, therefore additional care is required in relation to language sensitivity.	*Non-maleficence*	Formation of a RAG to sensitise the research design to issues relating to studying a sensitive topic (see Sections 1.2, 4.4. and Appendix 1).
Recruiting women on the basis of their BMI may be embarrassing for some women. Women may be unlikely to volunteer to take part in the study if they are not given an opportunity to assess researcher's position on 'maternal obesity'.	*Non-maleficence* *Justice*	Providing women with an opportunity to meet with the researcher prior to consenting to take part in the study. (Section 5.1 and Appendix 2).
Risk of miscarriage or pregnancy loss. Repeat interview study increases the risk of attrition, as medical literature shows that larger women may experience pregnancy loss or complications during pregnancy, therefore, on-going communication with pregnant women presents additional ethical concerns.	*Non-maleficence*	Use an NHS gatekeeper to check participant wellbeing prior to contacting women at each stage of the study in order that appropriate contact takes place (Section 4.6 and Appendix 2).
Reseat interview design with lengthy gaps between interviews. Participants may need reminding of the study aims and limits to confidentiality.	*Non-maleficence* *Autonomy*	Repeat informed consent procedures at each meeting (Section 4.7 and Appendix 2).
Protection of privacy - this research involves asking participants about their private thoughts and feelings which	*Non-maleficence*	Participants will be asked to give permission for interviews to be recorded, stored and transcribed. Identifiable personal data will be collected from

they would not necessarily share in the public domain.	*Autonomy*	participants and entered onto a form detailing basic information (name, address and demographic details). This will be kept separately from interview recordings and transcripts in a locked cupboard. All interview data will be stored under a pseudonym and kept securely (see Appendix 2). The research site will be kept confidential.
Right to adequate information about the purpose and potential impacts of the research. Participants recruited from within NHS: risk of participants feeling obliged to take part.	*Autonomy* *Justice* *Non-maleficence*	Information about the study and the implications of being involved with the study will be clearly explained to prospective participants so that participants understand that their care will not be impacted on by not taking part in the study (see Appendix 2).
Informed consent - legal responsibility to ensure participants understand the purpose and implications of the research. MHP may disclose poor practice which would need to be addressed. Participants may disclose potential self-harm or harm to others which would need to be addressed.	*Non-maleficence* *Autonomy*	Participants will be given adequate information to allow them to make an informed decision regarding taking part in the study, adequate time to consider taking part and understanding their right to withdraw at any point (Section 4.7.4). Limits of confidentiality regarding harm to self and others will have been fully explained and agreed (Section 4.7.4 and Appendix 2). MHP will be advised about limits to confidentiality relating to disclosures of poor practice.
Consideration to participant wellbeing – participants may have had previous negative experiences relating to their weight. Participants may become worried about their own and their unborn infant's wellbeing due to the risk status of the pregnancy. MHP may also experience situations which they find difficult to talk about due to negative emotions.	*Non-maleficence*	Provide participants with an opportunity to review the interview and feelings of taking part in the interview. Care will be taken in responding sensitively to participants' feelings. Participants will be reminded to discuss any concerns relating to the pregnancy with an appropriate MHP (Appendices 2 & 11-13).

4.7.1 Interviewing women in early pregnancy

Having imagined that the experience of pregnancy begins when a woman discovers she is pregnant, I planned to interview women early in their pregnancy to capture their early experience prior to any significant contact with MHP. Research on early

pregnancy suggests clear social norms relating to the disclosure of pregnancy: women tend to keep their pregnancy a secret until they feel the risk of miscarriage[40] has passed (Modh, Lundgren & Bergbom, 2011; Ross, 2015b). This practice is believed to have originated due to societal responses to miscarriage which make it difficult for women to talk about and have their loss validated[41] (Adolfsson *et al.*, 2004; Freeman, 2017).

As pregnancy can be unpredictable and participants may experience a pregnancy loss, I needed to carefully consider when I would recruit women to the study, and also how I would respond in the event a pregnancy loss occurred. However, deciding an appropriate point to recruit women to the study was a contentious issue, dividing the academic supervisory team who were involved in the early stages of the study. Based on my counselling experience, I felt strongly that the silence surrounding early pregnancy was problematic. I noted that current societal expectations to keep pregnancy secret also meant that women were expected to experience miscarriage in secret (Goopy, St John & Cooke, 2006). However, *The Miscarriage Association* (2011) suggest that women's needs are varied and support should be tailored accordingly. Therefore, I anticipated that responding to women on an individual basis would be challenging, as I would lack personal knowledge of women's wishes.

In regard to these concerns I applied the principle of non-maleficence, feeling that it was better not to intrude too early in pregnancy, as it may be perceived as a deeply personal and private event. Following consultation with the RAG and the supervisory team it was decided that women would be recruited to the study after 12 weeks gestation, following the foetal dating ultrasound scan which takes place at 11-14 weeks (see Appendix 2). This strategy meant that women would perhaps feel more secure about their pregnancies (Katz Rothman, 1988) as the risk of early

[40] In the UK, the term miscarriage describes the loss of a pregnancy during the first 23 weeks. Following this period, the term stillbirth is used.

[41] There are few rituals which support women who have experienced early pregnancy loss which may enhance women's feelings of sadness and isolation (see for example, the Stillbirth and Neonatal Death Charity (SANDS) and the Miscarriage Association who work closely with families and professionals to raise awareness of women and family's needs relating to pregnancy losses).

miscarriage[42] would be reduced. This approach would also allow me to exclude women should their ultrasound scan indicate problems, and would enable me to identify and exclude women with complex pregnancies[43]. My strategy meant that the interviews would not take place until the 15-17th week of pregnancy. However, this would allow me to focus on early pregnancy experiences and the first meetings with the community midwives, midwife sonographers and obstetricians.

It was also decided that prior to contact with women for the first and subsequent interviews I would check with the NHS gatekeeper to make sure all was well with the pregnancy (see Appendix 2). This strategy would ensure that I did not inadvertently contact women in the event of a pregnancy loss, or other pregnancy complication.

4.7.2 Ethical concerns relating to interviewing women in late pregnancy

Losses in the second[44] or third trimesters of pregnancy are often regarded as markedly different from early losses, and women may find that their loss receives greater societal validation (Goopy, St John & Cooke, 2006). In contrast, late pregnancy losses and stillbirth, although less common, tend to receive greater societal acknowledgement and support (Plagge & Antick, 2007). The societal response to late pregnancy loss may be in part due to the work of various charities in helping parents and families have their grief recognised, and in the guidance provided to professionals who support parents through all types of pregnancy losses (e.g. SANDS; The Miscarriage Association). In imagining how best to respond to women in ways that were ethical, again I was largely guided by current sociocultural conventions and the principle of non-maleficence.

In discussing this issue with the RAG and the supervisory team, members were divided on how to respond to research participants should a late miscarriage or

[42] The medical literature on early miscarriage suggests that the incidence of miscarriage varies according to factors such as age. In women under 40 one in five pregnancies ends in miscarriage (RCOG, 2016).
[43] Complex pregnancies include multiple pregnancies and women with co-existing medical conditions.
[44] Second trimester pregnancy loss is termed late miscarriage by the Miscarriage Association (2016) and related to pregnancy loss between 14 and 24 weeks gestation.

stillbirth occur. Some members felt strongly that any contact from a researcher would be unwelcome. My own reflection on this important ethical issue was very much influenced by my counselling experience, my personal experience of infertility and assistive conception and my academic knowledge of the ways that individuals tend to respond to grief and loss from a psychological perspective (e.g. Bowlby, 1961; Parkes, 1972; Worden, 1983). I knew that people sometimes wish to avoid all reminders of their loss, whereas others wish to have their pain validated or acknowledged. Again, working from the ethical standpoint of non-maleficence I felt that it would be uncomfortable for me to withdraw a participant without acknowledging, even in a small way, what had happened. At the same time, I was also aware that people need privacy in loss (Basinger, Wehrman & McAninch, 2016). Additionally, having met with participants to discuss their experiences of pregnancy over the course of one or two interviews, I imagined that it was highly likely that I would have formed a researcher/participant relationship, and that the participant might wish to have some acknowledgement of her loss. Therefore, it was decided that, in the unlikely event that a stillbirth occur, I would send a message of sympathy to the participant before withdrawing them from the study (see Appendix 2). By doing so I also acknowledged the moral principle of autonomy, in that the participant would be able to contact me in the future should they wish, in the knowledge that I was aware of what had happened to them. Responding reflexively to this aspect of the study meant I had to examine and balance my own need to extend sympathy and observe societal conventions with what I imagined grieving women might want.

Wishing to capture the middle and later stages of pregnancy, I planned to follow up the first interview with a further interview at 32-34 weeks gestation. I felt that this was as late into the pregnancy as was practical; bearing in mind that some of the medical literature suggests that larger women may not carry their babies to term (Bhattacharya *et al.*, 2007). This second interview would focus on the later stages of the pregnancy, also following up topics raised at the first interview. As I wanted to explore experiences of childbirth, I aimed to conduct the third and final interview fairly soon after childbirth. However, I also wanted to ensure that I did not intrude on what I imagined would be a hectic and private family time. Therefore, I planned this

interview for 2-4 months after childbirth. I anticipated this interview would be longer in duration than the previous interviews as I knew from the healthcare literature that women are often keen to share their experiences of childbirth (Callister, 2004).

4.7.3 Privacy and confidentiality

Having set out the study design and the ethical principles informing the design, in the following sections I discuss privacy and confidentiality and how these relate to the design of the study materials and practices relating to informed consent.

As the nature of social research pivots on participants being asked to share personal thoughts, feelings and experiences, privacy and confidentiality are central ethical issues (Kimmel, 1988). Wiles *et al.* (2008) suggest that, in the context of research, confidentiality involves two main aspects: firstly, not sharing information which has been provided by participants; and secondly, making sure that participants' identities are not inadvertently revealed in the presentation of the research findings.

Privacy and confidentiality are therefore closely related to non-maleficence. Privacy can be defined as: "the claim of individuals, groups, or institutions to determine for themselves when, how, and to what extent information about them is communicated to others" (Westin, 1968, cited by Kimmel, 1988: p.86). Confidentiality "refers to agreements between persons that limit others' access to private information" (Sieber, 1982, cited by Kimmel, 1988: p.86). Therefore, when privacy is discussed in the context of social research it firstly, refers to the right of participants to choose whether to share information in the course of the research, and secondly, participant's right to withdraw from the study or withhold information. Confidentiality refers to the rights of participants to request information or data is not shared with others without express permission. In terms of confidentiality in relation to the current study, the participant information materials assured participants: "your real name will not be used within the study report" (see Appendices 3 & 4).

Breaches of privacy represent damage to the participant brought about by the breaking of confidentiality, by sharing information which may embarrass or discredit them (Kimmel, 1988). Confidentiality and anonymity are also closely related in that should confidentiality be broken (due to information or data sharing) then a

participant's identity would be revealed. Some circumstances limit the extent to which confidentiality can be agreed or guaranteed, these relate to the protection of vulnerable individuals from harm, and serious criminal offences (Wiles *et al.*, 2004). In relation to the current study following these guidelines meant explaining the limits to which confidentiality could be assured and checking that the participant was in agreement to these limits. In doing so participants can act with autonomy, deciding what information is shared and knowing how such information would be handled.

4.7.4 Designing participant materials: informed consent

From a moral standpoint, seeking and obtaining informed consent from research participants represents respect in terms of human autonomy (van Den End & Pelle, 2014). Wiles *et al.* (2007) highlight that there is a general lack of consensus in the field of social research as to the nature of informed consent. However, a definition proffered by The British Sociological Association (2002) emphasises the researcher's responsibility to "explain as fully as possible, and in terms meaningful to participants, what the research is about, who is undertaking and financing it, why it is being undertaken and how it is to be disseminated" (Social Research Association, 2003: p.28.). Furthermore, informed consent is defined as: "a procedure for ensuring that research subjects understand what is being done to them, the limits to their participation and awareness of any potential risks they incur" (Social Research Association, 2003: p.28). Highlighting that participants understand the nature of the research makes clear the *relational aspect* of informed consent, in that it is implied that the researcher makes an assessment of whether the participants comprehend the nature of the research, and its potential impact on the individual.

With this in mind, Wiles *et al.* (2007) argue that, in practice, it can be difficult to strike a balance between providing participants with enough information for them to imagine what it might be like to take part in a study, and putting them off participating. Finch (1884) suggests that the nature of narrative interviews makes guaranteeing confidentiality particularly problematic in terms of how to anticipate and explain to participants the ways their data will be used and how they will be represented. Beauchamp and Childress (2009) describe three aspects which are important to consider in relation to consent. Firstly, participants need to be provided

with enough information so that they understand what they are giving consent for. Secondly, they must understand that they are not obliged to participate, and they can withdraw at any point without giving a reason. Thirdly, that the participant is fully able to understand what taking part in the research involves and that they have the capacity to make an informed choice. Taking note of these considerations, I constructed *Participant Information Sheets* (see Appendices 3 & 4), giving as much information as possible. I also planned to ensure I gave participants ample opportunities to ask questions and reflect fully on their decision to take part in the research before giving consent (see Appendices 5 & 6).

4.7.5 Conclusion

In this chapter I have discussed my approach to studying human experience and sensemaking through the lens of social constructionism. I have also set out my understanding of stories as they relate to experience, detailing how stories represent a means for conceptualising, exploring and understanding embodied experience. Drawing on Ricoeur's (1984, 1991) concept of narrative identity and Gee's (1999) articulation of discourse, I suggested a conceptual framework for thinking about how we come to emplot and understand our experiences. I also discussed how stories provide an important means with which to investigate the ways larger women's and MHP experiences are interwoven, revealing more about how the experience of MHC shapes pregnant embodiment.

In the second part of the chapter I set out the research design. Having suggested experience is always contextualised and inherently discursive (Maynard & Purvis, 1994), I suggested that a repeat interview study was appropriate to exploring the experience of pregnancy in that this design would help to explore how the context of MHC shaped pregnant embodiment over time. I also set out a rationale for single interviews with MHP which would enable me to study how MHP framed and understood their practice in relation to larger women's care. The chapter also detailed the consideration given to the timing of interviews with pregnant women and the important ethical decisions made about how to handle situations relating to pregnancy complications and pregnancy loss. I detailed my approach to contacting pregnant women for second and third interviews and the ways I ensured

inappropriate contact was not made if women had experienced a miscarriage. I ended the chapter by discussing ethical issues relating to privacy, confidentiality and informed consent.

Chapter 5 Methods

5.1 Part 1: participant recruitment and interviews

In Part 1 of this chapter I describe the recruitment of participants to the study. I also draw on my field notes to demonstrate the reflexive aspects of the research, detailing how critical reflection shaped my engagement with participants during data collection.

5.1.1 Recruitment

Pregnant women

I recruited women by sending them an invitation letter to their home via the NHS gatekeeper (see Appendix 7) and a participant information sheet (see Appendix 3). The invitation letter was sent following the booking appointment with the community midwife. I also promoted the study using posters and leaflets (Appendix 8 & 9) within the antenatal department of the study hospital. I met with members of the antenatal team, administrative staff and groups of community midwives, and midwife sonographers to discuss the study and study participation.

Of the 46 women who were invited to take part in the study 8 women responded positively to the invitation, either agreeing to meet with me at the antenatal clinic following their ultrasound scan or by volunteering to take part. 6 of the 8 women who had showed interest in the study agreed to participate. The remaining 2 women changed their mind prior to meeting with me. Recruitment took around 6 months and was greatly assisted by a midwife at the antenatal clinic who raised study participation during her assessment with the women. Subsequently, 4 of the women who took part in the study did so due to her efforts[45]. Only one woman (Anna) wanted to meet with me at the antenatal clinic prior to consenting to take part in the study, the other participants were happy to agree to the first interview based on the

[45] This midwife also volunteered to take part in the study and showed a high degree of interest in the study and the potential study outcomes. During her own interview with me as a participant she discussed her own weight-related concerns and feelings about her larger body. She commented that she found it easier to talk to women about their weight as she was obviously larger herself and she suspected that women felt less defensive when she raised the topic of weight. Her interview and interest in the study helped me to develop my thinking about the ways that MHP embodiment acts on the context of MHC.

participant information they had received and the discussion with the midwife at the antenatal clinic. The interviews with the women took place between the 28th of November 2013 and the 10th of February 2015.

The women who took part were all between 22 and 34 years of age and all of them were employed, mainly in semi-professional and professional positions. Their educational backgrounds varied from secondary school education to post-graduate Masters qualifications. At the beginning of their pregnancies, 2 of the women lived with their partners in privately owned property, the other 4 lived with family members. Only the women living in privately owned property had planned their pregnancies whereas the other participants' pregnancies were unplanned, and the pregnancy therefore also impacted on the wider social contexts of the women's lives. 5 of the women were born in the UK, one of these women's parents were born outside the UK, one woman had moved to Scotland from Eastern Europe.

Although my account of the recruitment of women to the study looks relatively straightforward, recruiting women on the basis of their BMI felt awkward. As I have already indicated, I foregrounded ethical concerns in planning this research and I also adopted a reflexive approach to each stage of the research process. To demonstrate how reflexivity informed the construction of the research data I pause here briefly to describe meeting Anna and her husband Alan at the maternity hospital to discuss possible participation in the study (see excerpt from field notes below). Anna was the first woman to be recruited to the study and meeting her led me to further reflexive thinking in relation to the body in social interaction. Ultimately meeting Anna led me to consider in more detail the ways that the body influenced the construction of the data.

> I met Anna and her husband 'Alan' in a room at the antenatal clinic for a short meeting to discuss taking part in the research. I was surprised when I saw Anna and I realised in that moment that I had no idea of what the embodiment of a BMI of over 35 would actually look like. Looking at Anna I found it hard to imagine how her body would cause herself and her unborn infant any medical problems. She clutched an oversized handbag in front of her stomach and told me she was happy to take part in the research. Alan, who had a larger body size himself, sat beside Anna nodding his head in agreement. At this point I was acutely aware of her self-

> consciousness about her body, I felt conscious of my own body and wondered if I should try and conceal my own stomach. I felt small and self-contained as if my body had the potential to accuse Anna of some misdemeanour. Looking at Alan I could see that he had a body size and shape that would not be easy to manoeuvre and of a size which would certainly attract attention. I was aware of the judgments I was now making in relation to Anna's participation in the study and Alan's part in this. The impressions that both Anna and Alan's bodies were having on my thinking made me acutely aware of the unspoken dialogue between our bodies.

Reflecting on my first meeting with Anna helped me to consider in more depth how the research participants might perceive the size and shape of my body, helping me to consider how my body might influence the research process. Both Ellingson (2006) and Burns (2006) argue that it is important to consider embodied difference when people are in dialogue. Therefore, it seems prudent to consider how the body might be read intersubjectively in the context of the research interview.

Although reflexivity is widely acknowledged as an integral aspect of qualitative research, requiring consideration at each stage of the research process (e.g. Oakley, 1981; Wilkinson, 1988; Reinharz, 1992), embodiment is a neglected aspect of reflexive thinking in the context of interviews (Burns, 2006). Citing Shildrick (1997), Burns (2006) describes the ways that the body is read in social interactions as "leakiness between oneself and others" (p.8). She suggests the body is not absent from our communications, nor is it 'neutral'; rather it is fully present within the context of intersubjectivity. Taking forward Shildrick's (1997) metaphor of the 'leaky body' in the context of the current research provides a visualisation of the presence of the body in the interview space. Burns (2006) comments that in the interview we are not just heads without bodies. Therefore, we cannot leave the body out of our reflexive thinking.

Drawing on Burns' (2006) argument of the need to bring the body into the interview I reflected on what Bacon (2009) calls 'thin privilege'. In doing so I imagined my body as representing a powerful subject position. Following Burns (2006), I considered how the leakiness between bodies might affect the nature of the interview dialogue. I imagined my body and the participant's body conversing in terms of the discourses on which our understandings of our bodies are made. Mindful of this

leakage and the potential effects of it on the interview dialogue, I imagined how best to acknowledge embodiment in the context of the interview.

Literature had sensitised me to the fact that I would be interviewing women who were likely to have previous negative experiences on account of the size of their bodies. Furthermore, due to these experiences, I recognised it may be more difficult for larger women to relate to, or talk openly with, a person with a smaller body. Furthermore, I realised that as a 'slim' woman I was able to occupy a particular subject position. Bacon (2009) names the position 'slim' people take in society as 'thin privilege' which she says occurs due to the fat phobia predominating Western culture. Thin privilege exists due to the pervasive belief that, as fatness is so strongly despised, people must *choose* to be larger. The effect of this thinking is that smaller people are able to take the moral high ground; claiming privileges which are not available to larger people. Bacon's (2009) concept is useful in that it alerts us to the moral positions afforded according to body size.

With heightened awareness of the potential that my body would 'leak' and 'speak' in the interview context, I approached the interviews with an increased concern about the ways I might communicate judgement or reinforce maternal obesity or mainstream obesity discourses. I imagined my body would signal a position within these discourses, influencing how the participants positioned their talk in the context of the interview. I was aware that they might read my body as a 'healthy' or 'disciplined body', and that by reading my body in that way, the participants may also feel the need to make their own position within obesity discourses clear by representing themselves as 'healthy eaters' or 'exercise addicts'. In fact, I found that it was not just through talk that women represented themselves within these discourses, as I found out when I conducted the first interview with Anna (see, excerpt from field notes Chapter 1, p.1).

Reflecting on these fieldwork notes made me aware that I did in fact pay more attention to what larger people were eating in cafes, and what they had in their shopping trolleys. This is something Tischner and Malson (2008) discuss in relation to the public surveillance of larger people in shops and cafes. I theorised that, as I was not so interested in slimmer people's eating, perhaps I was also not so interested

in judging them as ‘over eaters’ or ‘unhealthy eaters’. It was with this heightened awareness that I entered the research field and although I end this reflective commentary here, I will return to consider my ongoing contribution to the construction of the study data at various junctures of the thesis.

MHP

Recruiting MHP was more straightforward than recruiting the women and was greatly assisted by the NHS gatekeeper who sent out an email with an attachment invitation letter (see Appendix 10) and participant information sheet (see Appendix 4) to MHP who met the inclusion criteria which I discussed in Section 4.5.2. Subsequently, I recruited 5 obstetricians, 6 midwives and 2 anaesthetists (see Table 5.1).

Table 5.1 MHP participants

Pseudonym	Main role	Previous experience
Lesley	Community midwife in busy urban community practice.	Qualified in 1997. Previously worked in the labour and postnatal wards. Also has experience of providing parentcraft and breastfeeding support.
Emma	Community midwife in a small rural community practice.	Qualified in 1995. Previously worked in the labour and postnatal wards. Also has experience of neonatal care and care of women who have experienced miscarriage and stillbirth.
Jodie	Midwife in the antenatal clinic at the maternity hospital. Role includes antenatal screening and gathering information from women when they attend appointments with the obstetrician.	Qualified as a midwife in 2000. Has previous nursing experience prior to becoming a midwife. Has worked in prenatal and postnatal wards and the labour ward.
Sadie	Charge midwife in the labour ward.	Previous nursing experience. Has worked in the labour ward since qualifying in 2005.
Amy	Midwife specialising in midwifery education.	Qualified in 2007. Previous charge midwife in the labour ward predominantly obstetric unit, but also has some responsibility for the midwife-led unit.
Beth	Midwife currently working in the postnatal wards.	Previous nursing experience. Qualified as a midwife in 2001. Has experience of prenatal care and the labour ward.
Sarah	Consultant obstetrician.	Took up post as a consultant six months prior to the interview having spent the previous six years

		training within the same maternity hospital. Clinical role involves obstetrics and foetal scanning.
Emily	Consultant obstetrician. Foetal medicine specialist.	Has been a consultant obstetrician since 1995. Has worked in the research site for the last seven years. Role involves prenatal testing in foetuses where an abnormality is suspected.
Kenneth	Consultant obstetrician.	Has practiced obstetrics and gynaecology since 1983.
Eileen	ST3[46].	Fourth year as an obstetrician, having come to work at the research site in 2010. At the time of the interview Eileen was herself pregnant with her first baby and was on maternity leave.
Lucy	Part-time obstetrician and part-time research fellow.	Has specialised in obstetrics and gynaecology for the last 9 years
Angela	Consultant anaesthetist.	Became interested in anaesthetics at medical school because of the diversity of specialities available, enjoys the patient interaction.
Alex	Consultant anaesthetist.	Became a consultant in 2004. Main interests, obstetric anaesthetics and post-graduate medical education.

These MHP represented various levels of experience including consultant obstetricians, an ST3, community midwives, and midwives based in the maternity hospital working in antenatal, labour ward and postnatal settings. The anaesthetists were both consultant anaesthetists. The interviews with MHP were conducted between 28th January and the 10th of October 2014. The timings of the interviews allowed for transcribing and early analysis to commence simultaneously with the data collection phase.

5.2 The interviews

The interview topic guides (see Appendices 11-14) were designed to guide the interview talk while allowing the participants to 'tell their own stories' (Mishler, 1986; Riessman, 2008) about the topics relating to the study research questions. I used open questions such as: "tell me about finding out you were pregnant"

[46] In the UK a medical training takes 6 years to complete. This is followed by a two-year Foundation Training Programme (FT1 and FT2) and a 7 year Specialist Training Programme (ST1-6). On completion of this programme candidates may apply for a consultant position (Medical Schools Council, 2018).

(women), or “can you tell me about your experience of managing the pregnancies of women with BMI over 35?” (MHP). I followed up the participants’ responses with further prompts and probes where I reflected what I understood the participant had said and asked for further detail.

On beginning the interviews I became aware that participants invariably took a position in relation to healthy eating discourse (as illustrated by my field note excerpt in Chapter 1). Reflecting on the interviews I noted that many of the participants tended to warrant themselves as ‘good neoliberal citizens’ by defending positions that they were not questioned on - not by me in the context of the interview at least. In making my field notes I noted that I found it extremely difficult not to evaluate what participants said about eating and found that I was continually drawn to any talk about the type of foods they said they ate. I also noted that this was more so in the case of participants with larger bodies. For example, when Anna talked about craving doughnuts, I was drawn to automatically processing this talk through healthy eating discourse, such is the pervasiveness of neoliberal obesity discourse (Guthman, 2009).

I was keen not to reinforce mainstream obesity discourse and judge the participants in the process. Therefore, during the interviews, I used counselling techniques based on ‘active listening’ whereby listeners communicate their understanding of the speaker’s meaning through paraphrasing and reflection of feelings (Rogers, 1942). This is somewhat easier to do in interviews than in ordinary conversations as the focus of the interview is on the participant’s experiences rather than those of the interviewer. Through using these counselling skills, I was able to communicate empathy and suspend judgement which I later found out through post-interview conversations with the pregnant women, was an important factor as to why they enjoyed talking with me.

When I began the interviews with the MHP I was mindful that, although I was politically sensitised in relation to anti-obesity discourse, they were unlikely to share my background and my relationship with the women. Therefore, I recognised that they were perhaps more likely to draw uncritically on medical anti-obesity discourse to make sense of their work with larger women. I also anticipated and appreciated

that they may have felt uncomfortable talking with me about issues relating to weight and the handling of the larger body.

When making fieldnotes, following these interviews I came to realise that my critical reflection on the interview process represented the beginnings of data analysis, helping me to analyse participant positionality in the stories they told me. For example, having reflected on and identified the ways I drew on anti-obesity discourse to understand my own embodiment meant that I could also identify the ways that MHP positioned themselves as healthy 'good' citizens, enabling them to position themselves in contrast to the larger women in their care.

When I began analysis, I found that the 'character' of the women's and MHP interviews were markedly different. By character I mean the types of talk and the conversation conventions participants observed during the interview. The interviews with the women were much longer than the MHP interviews. The obstetricians' interviews were more difficult to conduct (in comparison with the midwives and anaesthetists). Some of these interviews were quite short; with the shortest lasting only 33 minutes. I found that, with the exception of Eileen (ST3) who talked quite candidly about her-experiences, the consultant obstetricians tended to restrict their responses, rarely elaborating their points, even with further prompts and probes from myself. This was most noticeable in relation to handling and working on larger women's bodies. The effect of this was that the nature of the talk in these interviews, on the surface at least, appeared to reveal little about how the obstetricians felt about larger women, as often they presented a very neutral view by keeping their opinions hidden.

5.2.1 Reflection on the research relationships

Wishing to gain a deeper understanding of how my relationships with the participants shaped the data we constructed, I engaged in further reflexive work in conjunction with feminist writing on research relationships. Feminist understandings of the research interview characterise the researcher/participant relationship as based on emotional engagement, trust and honesty (Fontana & Frey, 2000). In considering forming an appropriate researcher/participant relationship, I was guided by Birch and

Miller (2000) who suggest that 'good' research relationships should allow participants to feel comfortable enough to talk about private thoughts and feelings.

The literature on the topic of 'obesity' sensitised me to the hesitancy larger women and MHP might have in discussing issues related to larger embodiment. I felt participants would need time to consider how much information they wanted to share with me based on our rapport and how they felt I might represent them in the research. This concern related to all the participants in that I was aware that MHP may not want to talk about the care of larger women due to worries about representation.

I did however, anticipate that the relationship I developed with the women would be different from the MHP due to the prolonged contact I would have with them during their pregnancies. Birch and Miller (2000) propose that in participating in repeat interview studies, such as those I conducted with the women, participants and researchers are more likely to share both personal and private experiences more readily than in other types of research. The extended time spent in talking about personal matters may somewhat mirror a therapeutic interview (Day-Sclater, 1998; Clark & Sharf, 2007). Therefore, a high level of reflexive engagement is required to ensure participants are not exploited in the context of the research.

In repeat interview studies participants are expected to maintain a commitment to the research over what can be an extended period of time, therefore, when I planned the interviews I anticipated that women may drop out of the study for a variety of medical and personal reasons. However, this did not happen which led me to reflect further on why this might be. In considering the relationship I had formed with the women I realised that initially I thought of the research relationship as unequal and felt I was 'taking' something from the women. However, during the course of fieldwork I realised that I was also giving something of myself, and that the exchange felt more equal than I initially imagined.

Wishing to gain a deeper understanding of the research relationship, I explored informally with some of the women what it meant to participate in the study. This normally happened when the digital recorder was switched off and we were

reflecting on the interview. Through these conversations I was able to see that the women viewed their contribution to the study as potentially 'making a difference' to the care of pregnant women, and that this was quite motivating for them. However, it was also obvious that as most of the interviews were lengthy, usually over an hour and sometimes extending to as long as two and a half hours, the women were getting something out of the interview experience. Reflecting on the interaction between myself and the women helped me to understand that I was experiencing the research relationship somewhat differently from other professional relationships I had experienced which felt more 'business-like'.

All the interviews, with the exception of one interview, were carried out in the women's homes at their request. Furthermore, after the first interviews with the women I noticed that the nature of the relationship had changed in that we now had shared 'an experience' and were relating to each other differently. In some ways this felt similar to the counselling relationship (making me mindful of the power imbalances which exist when one person shares their views and feelings and the other doesn't). However, this relationship felt different, it was more friendly in that we did more 'normal' things. For example, Anna and I sat side by side on the sofa eating the homemade gingerbread she had made, drinking tea and laughing at some of her very funny stories about her astonishment at how her body was misbehaving in pregnancy. Angie met me at the shops because she was in town when I arrived, and we had a quick look around the shops on the way to her house, she also dropped me at the station after an interview as she was going to collect her grandmother from work. Vron collected me from the university and we went to her friend's house for her final interview to "save me getting the bus". Similarly, Susie's husband dropped me at the station when we realised that we had talked for so long that I was in danger of missing my train. Nicola and Kacey, despite experiencing ill health after the birth of their babies, stayed in touch and invited me to meet with them to complete the final interview when they felt well enough to do so. All of these acts of kindness, care, and engagement in the research process, signal to me that the women wanted to share their stories with me and had found some value in doing so.

The engagement the women seemed to have in the research can of course be interpreted in various ways. I like to think that the women felt comfortable with me, we shared a rapport and they felt valued by me. Equally, I am alerted to the power I have as a researcher in terms of participant 'voice' and the responsibility I have towards the participants in terms of non-maleficence.

Having begun the interviews with the MHP, on reflection, I felt that my single interview design had limitations in that there was little time to build rapport prior to the interviews. In a similar vein, there were also limited opportunities for joint post-interview reflection. With these issues in mind I felt that MHP may have felt less inclined to talk in depth about the aspects of their work they found most rewarding and/or most challenging. It was at this point in the research that I realised the implications of conducting research which was likely to reveal two sides of a contested story. Through further reflection I realised that I needed to think carefully about how I presented the research findings in order that I could demonstrate equal regard and respect for all the participants' experience. My critical reflection led to the development of the methods I used to conceptualise and analyse the research data and present the findings. The development of these methods is described fully in Part 2 of this chapter.

5.3 Part 2: data analysis

5.3.1 Development of a method of analysis

On approaching analysis, I discovered I was unsure of how to begin. It was clear that I needed to do more thinking in order that I could develop a method capable of answering the research questions. This was particularly so in that I had already identified during the process of interviewing that the nature of the interview talk was so varied. I realised at this juncture that I needed to explore more fully literature which would help me to conceptualise and analyse narrative data. By doing so I was able to develop an iterative process which allowed me to conduct a rigorous analysis which fitted with my methodological framework. In the following sections I explain how I drew on: Mishler (1986), Arvay (2003) and Riessman (2008) to help me understand and conceptualise interview talk; Paley and Eva (2005) and Jefferson

(1979) in relation to identifying stories in interview text; and lastly, Polanyi (1981) to help me analyse why stories were told at particular junctures of the interviews.

5.4 Interviews as performance and the construction of storied data

My reflection on the differing nature of the research relationships and talk within the interviews helped to guide my reading and thinking about the way we perform in interviews. Generally speaking, qualitative researchers approach interview data as a means to understand everyday experience, however, social constructionists view them as a site of on-going meaning-making. Mishler (1986: p.34) suggests that qualitative interview data is in fact not gathered or collected, but is *created,* in what he describes as a "discursive accomplishment" in which *conversation* facilitates narrative discourse. And, events and experiences are made meaningful through a collaborative process of co-construction. Furthermore, according to Silverman (1991), rather than providing a 'window' into the lives of participants, interviews are best conceptualised as a way of understanding the *meanings* participants give to their experiences in the social world. As Miller and Glassner (2016) propose, this does not mean that we cannot gain knowledge of the 'real' social world, but that we need to do so by paying attention to the intersubjective aspects of data collection.

In considering the construction of meaning in the context of the interview, Arvay (2003) invites researchers to think about interviews as a 'dialogic performance' in which researchers and participants are involved in the co-construction of the interview text. Similarly, Riessman (2008) suggests that interviews are in this sense a 'dialogic environment' in which we *perform* our identities. The notion of the interview as a dialogic performance points towards an approach to analysing the ways that individuals perform their identities, positioning themselves within the stories they tell in the context of the research interview; providing a point on which to consider in more detail an approach to analysis.

In Section 4.3 I discussed the work that discourses do to get people recognised (Gee, 1999), and the role of narrative emplotment as a means to organise the fragmented happenings of our lives into stories which are capable of answering 'who, what and

why' questions: making sense of our experiences (Dowling, 2011). This thinking formed an important basis for my understanding of the interview as a site in which both parties work to have themselves recognised as being a certain kind of person (Gee, 1999; Rapley, 2012). Like Arvay (2003) and Riessman (2008), Elliot (2005) suggests that, in the context of the research interview, participants tell stories about their experiences in order to communicate something about themselves. This means that stories are always told for a purpose (Polanyi, 1981). Accordingly, analysts should pay close attention to the collaborative aspects of storytelling i.e. *why* is this particular story being told? What is the role of the interviewer in its construction? (Elliot, 2005). The focus is not so much on the content of the story i.e. how meaning is temporally ordered, but *how meaning is created*. Therefore, in the context of the research interview, stories are told by participants to tell the interviewer important information revealing the storyteller's stance on the topics contained in the conversation.

Recognising interviews as a site of on-going co-constructed meaning suggests that, when transcribing interviews, both parties' talk needs to be taken into account (Riessman, 2008). Bearing this in mind I transcribed the interviews in a manner which retained both speakers' contributions including pauses, non-lexical utterances i.e. umm, erm and repaired utterances. To help in retaining how speakers communicated meaning I drew on the writing of Gee (1985, 2011). Gee (2011) suggests that speakers invariably signal meaning using changes in pitch and tone of voice to signal to listeners information which is new or significant within "speech spurts" (p.128). He goes on to suggest that by identifying and marking speech spurts and emphasised words when transcribing produces transcripts which better capture speakers' meaning.

Following Gee's advice (2011) I paid close attention to the rhythmic and intonational aspects of the interview recordings. Doing so helped me to identify and capture meaning, emotion and expression in my transcripts and formed the first stage of my structural narrative analysis. However, I found applying this method of transcription to all the study data very time consuming. Despite this, I found it an invaluable means to retain aspects of speech which would have otherwise been lost. To aid this

process I used a software programme called Transana[47]. Although the transcription process is still manual, the software allows the transcription to be linked to the audio recording, facilitating a means to work between the recording and the transcript (see Transcription Key, p.xxi). Once completed I used this version of the transcript for two purposes: to identify the speaker's focus; and to identify sections containing narrative discourse and stories (as opposed to other forms of talk). I then focussed further attention on these sections for the next stage of my analysis.

5.4.1 Story analysis: early stages

Having conceptualised and fully transcribed the interviews I set about making decisions about how I would approach the analysis. I observed that the interview talk contained turn-taking, and moments when participants moved into and out of what Riessman (2008) describes as 'the story-world'. The interview text also contained distinct connected successions of happenings. Czarniawska (2004) describes this type of talk as narrative. I noted that these narratives were often held together by a motif (or a theme) which wove the interview talk together (Gee, 1999). Therefore, in the first stage of my analysis I familiarised myself with the types of talk present within the interview. I also noted any prominent narratives. Lastly, I made notes about motifs which were apparent at this stage.

Identifying stories

The next stage was to identify storied data, and to do this I drew on Paley and Eva's (2005, citing Prince, 1991) definition of a story. These authors suggest stories contain a plot consisting of four factors:

1. The inclusion of a character or characters
2. The character(s) face a problem (complicating action)
3. There is a clear connection between the character and the problem (an explanation)
4. The combination of these elements reveals the point or meaning of the story, and thereby, provokes an emotional response in the recipient of the story.

[47] Transana v3.00. http://www.transana.org.

Although Paley and Eva's (2005) writing was helpful in terms of identifying stories within the data I found that participants often told stories which extended across the whole interview with flashbacks and flash forwards (e.g. Elliott, 2005; Patterson, 2008; Squire, Andrews & Tamboukou, 2008). Therefore, stories tended to be woven throughout interviews in ways that sometimes made them difficult to distinguish from surrounding data. I realised I needed to develop a keen eye to ensure stories were not missed. One of the ways I did this was to draw on ideas from conversational analysis. Polanyi (1989) suggests that when speakers build a story into a conversation they use techniques, or devices, to build a bridge between the point the speaker is trying to make in their topical talk (turn-by-turn talk) and the story:

> a competent conversationalist does not begin a story at any random point, in any given turn, but tries to build a bridge from what is actually happening in the general state of talk to some state of affairs in the story world that can be thought of as relating significantly to what is happening in the interaction in which the story will be told (p.47).

Jefferson (1979) terms this type of talk 'entrance' and 'exit' talk. The topic talk triggering a story is the entrance talk, whereas exit talk is the device used to return to the topic talk. I found both these conversational devices useful in identifying stories. For example, I noted the MHP often made statements such as: "well when I first started"; "I think women are quite bad to each other"; "I remember being in"; "I remember that woman so clearly"; "In my mum's day". Using the concept of entrance and exit talk I was able to more clearly identify stories situated within the data.

I found that entrance talk also gave some indication about the relevance of the story to the topics being discussed: helping me to identify the meaning of the story. On this point, I noted that Polanyi (1981) writes that following exit talk, often story listeners will ask questions, or echo a point that has been made. Furthermore, she says, story listeners may also offer their interpretation of the meaning of the story, and this may instigate further talk on the story topic. When I examined the interviews, I found that I had indeed used this conversational device (a skill learned through my counselling practice). In fact, I noted that I tended to reflect my understanding of the point the speaker was making, and this greatly helped with analysis. In this stage of the

analysis I identified entrance and exit talk and made careful notes about my observations on how the story point linked with the surrounding text i.e. why was this story told at this particular point. I also reviewed my contribution, noting any questions or reflections I had made which preceded the story and checked participants' responses to my reflection of what I thought participants were communicating to me.

5.4.2 Deeper story analysis

Having identified the stories which were embedded within the interviews I then went on to analyse the stories. Following Gee (1999), I paid particular attention to the ways that characters, situations, actions, and artefacts were framed in the stories. I did this by firstly identifying story characters, the 'complicating action' and story resolution. I then moved on to analysing the meaning of the stories. To do this I drew on Polanyi's (1981) writing who suggests that storytellers invariably include three specific genres of information in their stories. These are: "events, durative-descriptive information and evaluative meta-information" (p.60). According to Polanyi (1981) it is the durative-descriptive information (i.e. what the story is about) which signals to the listener how they should evaluate, firstly, what's happening in the story, and secondly, why it is happening. Polanyi (1981) suggests that it might not be the plot so much as the durative-descriptive information which reveals the meaning of stories. She suggests: "stories" are often about the discrepancies between the "way that it ought to be" and the way it (usually) is […]. However, we use these abnormal happenings to display our beliefs about the normal and the expected" (p.100-101).

I used durative-descriptive information to provide further information about the thinking behind storytellers' positionality, doing so helped me to analyse the discursive framings larger women and MHP drew on to make sense of their experiences. I paid particular attention to the way that characters and artefacts were depicted, identifying the protagonist(s) and antagonist(s), making notes about how characters and artefacts were constructed. I looked for clues in the surrounding narrative, examining the assumption's storytellers made about how the story-world should operate.

I also noted that when a participant told a story in the course of an interview they usually did so to explain or justify something (the dialogic aspect of the analysis). Therefore, I explored in detail how the storyteller positioned the 'problem' (the way it ought to be), noting the broader narratives they drew on to make meaning in these stories.

I analysed how the problem was resolved (if it was), identifying the point the story made (often a moral point). I looked to the surrounding narrative and made notes about why the story had been told at that point in the interview. In this sense my approach to analysis was 'holistic' in that I analysed each interview as a separate unit rather than seeking to identify commonalities across the data set (Lieblich et al., 1998). Conducting a holistic analysis ensured that I could identify the broader narratives participants drew on in articulating the point of their stories (Lieblich et al., 1998). My approach to this task was guided by Jones' (2011) framework as a means to "see *through* [the body] to attitudes about bodies, health, and illness in the larger society and culture" (italics original, p.74). In conducting the analysis, I was particularly alert to how the body featured in the interview data as specimen, spectacle, and patient.

At the end of this process I had fully transcribed the interviews using an adaption of Gee's (2011) method which captured speakers' meanings within spoken text. I had also identified and analysed all the stories within each interview and had identified the key narratives which bound these stories and the interview together. For an example of my approach see Appendix 15 which details Sarah the consultant obstetrician's story: "I don't need any of that!"

At the beginning of the analysis I envisaged retaining my commitment to a holistic analysis by presenting the findings as composite stories based on individual interviews. This approach was in keeping with my methodological aim to avoid fragmenting the data. However, I discovered that I had too much data to present the findings in this way. To deal with this issue I decided to add another layer to my analysis by conducting what Lieblich *et al.* (1998) describe as a 'categorical analysis'. Categorical analysis involves identifying themes across multiple research participants' data. Guided by this writing I did what Lieblich *et al.* (1998) describe as

a ‘categorical-content analysis’. However, rather than sorting raw data into content topics I sorted the analysed stories according to the point stories made and the speakers’ positionality, i.e. midwifery stories about educating women or obstetricians’ stories about how the women’s body formed a barrier to the foetus. This approach also meant more rigour in relation to presenting findings in that I could use the categories I had identified as a means of ensuring coverage of prominent story themes. I also found that one of the benefits of categorising analysed stories and narratives in this way was that I could contrast the women’s and MHP experience. My approach also facilitated a means to compare the experience of different professional groups. Therefore, I was able to analyse how midwives, obstetricians and anaesthetists understood and made sense of their roles with respect to the larger pregnant body.

5.4.3 Construction of composite monologues and presentation of findings

In keeping with my commitment to exploring “the unfolding and interwoven story between healthcare professionals and patients” (Kalitzkus & Matthiessen, 2009: p.80), I wanted to find a method of presenting the findings which retained the individuality of experience but also demonstrated how the context of MHC shaped the experience of ‘maternal obesity’ and larger embodiment. In this sense I was keen to stay close to ‘participant voice’ (Stenhouse, 2014). However, I also recognised that I was inextricably involved in the construction of the data and the presentation of the findings in the sense that my voice would also be present. Therefore, I realised that my method of presentation must also acknowledge this aspect.

At the point of considering how best to present the findings I realised that I had identified many stories and narratives and organised them into broad themes. Now it seemed to make sense to reconstruct the stories and narratives according to the teleological principle into stories which retained the temporal features of the data, thereby, retaining speakers’ sensemaking, meaning and context.

Reconstructing the stories of many participants into a composite is a method drawn on in emancipatory research within the fields of disability studies (e.g. Papadopoulos, Scanlon & Lees, 2002) and critical race studies (e.g. Cook & Dixson,

2013), making this method suitable according to the aims of my research. Guided by this writing, and the most prominent themes I had found during my analysis, I selected women's stories according to stage of pregnancy. I also identified key MHP stories which corresponded to the women's stories. I found during this process that, as I had been so immersed in the data, I could hear the participants' voices as I worked to reconstruct their stories into a whole. I was reminded of a BBC television dramatization of '*Talking Heads'* by Alan Bennett which I watched with my sister and mother in 1982. I recalled the powerful effect of one particular story called '*A Woman of No Importance'* about a woman's experience of hospital care. The story was told as a monologue and its effects were poignant and powerful. I decided the composite stories would take the form of monologues based on stories told by individual participants. In line with my approach to identifying meaning in storied data (Gee, 2011) I ensured that the monologues contained a high level of verbatim text, staying close to the voice of the participants (Stenhouse, 2014).

As I wanted to demonstrate how the context of MHC shaped the women's experience of pregnancy and childbirth, I constructed composite monologues based on individual women's experiences. However, I found that the result was too wordy for inclusion within the thesis. I also noted that there was considerable overlap in the women's experience. Therefore, for the sake of brevity, and to avoid repetition, the findings chapters contain 9 sections of the women's monologues with the aim of representing the main themes found within the women's stories and narratives. All 18 of the women's monologues can be found within the appendices (see Appendices 17-22).

I also constructed 13 composite monologues to represent key themes found within the MHP stories and narratives. As I had previously found that the themes identified within the MHP stories related closely to the role and responsibilities of the MHP (i.e. the community midwives focus was different from the obstetricians), I decided to present the MHP findings according to profession. The composite monologues I produced are based on a central story told by an individual MHP, and are supported by similar stories and narratives, which other MHP told in the course of their interviews (i.e. stories about the antenatal booking appointment or the *High Risk*

Anaesthetic Counselling Clinic). For transparency each monologue is accompanied by a table detailing the titles of the stories and narratives which have been drawn on to construct the monologue. By taking this approach I meet my research aim which was to make a knowledge contribution about how MHP practices and MHC institutional discourse and practices shape larger women's experience of their bodies, pregnancies and childbirth.

In line with my social constructionist position I do not claim the monologues are representative of all larger women's and MHP experience of pregnancy and MHC (Rosenwald & Ochburg, 1992). Rather they offer accounts of participant experience which are open to various interpretations. I must also acknowledge that some stories remain untold in that they don't appear in the thesis. Furthermore, although I made every attempt to select stories which were representative of the themes I identified during analysis, I realise that I must also acknowledge my part in selecting the stories with which I constructed the composite monologues. Accordingly, to make more transparent how my personal and professional background, along with my ideological positionality have shaped the research findings I realised I needed to illuminate the choices I made about which stories within the findings chapters.

5.5 Conclusion

In Part 1 of this chapter, I described my approach to recruitment and described the participants who took part in the current study. I discussed how the study data was constructed during the in-depth interviews and described how the varied nature of the interview talk presented me with a challenge when beginning data analysis. I also set out how I conceptualised the type of talk comprising the interviews, providing information about how I engaged further with the literature on narrative analysis to resolve the difficulties I had in developing my approach to analysis.

The chapter also detailed the importance I gave to considering how the body acts in the context of the interview, potentially leaking unspoken societal discourse between bodies. In this respect, throughout the chapter I have attempted to provide a flavour of my reflexive process by discussing how I approached the interviews and also my relationships with the women who took part in the study.

In Part 2 of the chapter I described the methods I developed to analyse data. My method involved a 2-stage structural analysis helping me identify the discursive resources drawn on by women and MHP in relation to the context of MHC. I discussed the first stage of the analysis as involving a detailed approach to capturing the meanings contained in spoken English in transcriptions by using methods described by Gee (2011). I also described how this approach helped me to retain the co-constructed elements of speech which was important given my epistemological approach.

In the second stage I described my approach to the structural analysis of stories. Detailing how I recognised and analysed stories. The method I describe was supported by also considering the 'dialogic performance' context of the interview (Riessman, 2008), and involved paying attention to why stories were told at particular points of the interview. I argued that this aspect of the analysis revealed the positionality given to the characters and events; providing me the means with which to make a knowledge contribution about how MHP practices and MHC institutional discourse and practices shape larger women's experience of their bodies, pregnancies and childbirth. I ended the chapter setting out my novel approach to presenting my research findings as a series of monologues following the journey larger women take through MHC.

Chapter 6 Early pregnancy

Over the course of the next 3 chapters I present the research findings in the form of composite monologues. This chapter presents and discusses findings in relation to early pregnancy. Chapter 7 focuses on the middle and later stages of pregnancy, and Chapter 8 addresses childbirth and the early postnatal period.

All the monologues contained within the findings chapters are drawn from the analysed stories and narratives are written to ensure coverage of the themes found (see Tables 6.1-6.4). Each monologue is written from the viewpoint of a pregnant woman or a midwife, consultant or anaesthetist and follows the journey women take as they interact with the context of MHC during their pregnancies. The journey begins with the women's prenatal experience and ends with postnatal care.

Table 6.1 Women's stories and narratives

Theme	Description
The struggle for control	The effects of hormones which make the body unpredictable and alter the way the body feels (i.e. cravings, mood swings). Feeling that your body is not your own. Can also relate to colonisation by hormones, the pregnancy, and also clinical interventions i.e. induction of labour and regional anaesthetics. Also associated with high levels of emotion work and co-operating and/or resisting medical advice/intervention.
Containment	Stories about how women or the body are contained. Stories in this theme relate to difficulties with being able to move the body i.e. tiredness/exhaustion, and also the times when movement is restricted due to mechanical and chemical means (i.e. during and after epidural and spinal anaesthetics).
Womb and foetal permeability	The notion that the foetus is vulnerable to external influences: can relate to foodstuffs and infection. Includes stories about trying to control the size of the foetus.
Being in/visible	Stories which illuminate that larger women are highly visible but simultaneously invisible (Tischner & Malson, 2008; McCullough, 2013), for example, when the women feel they are targeted by MHP and labelled as poor eaters or potentially lacking in mobility or agility. On these occasions women are rendered invisible as individuals due to the assumptions made about them.
Seeing is believing	Stories where women doubt their visceral sensing of their bodies, preferring to trust the data from biotechnologies. Also the occasions women feel tentative towards early pregnancy and seek reassurance from biotechnologies.

Anything can happen	The notion that pregnancy is unpredictable. Also related to notions about trying to gain control. Includes stories about the '12-week rule' (Ross, 2015a) and seeking medical help. In later pregnancy this theme draws attention to how discourses of foetal risk are evoked and embodied.
Reproductive citizenship	The notion that women should privilege foetal wellbeing over their own, accepting individual responsibility and blame for wrongdoing. Includes notions of seeking to control the body through effort, making 'good choices', following medical advice, and expecting complications. May also relate to making up for previous mistakes and seeking new ways of controlling weight-gain in pregnancy. Also includes stories of healthcare interactions about lifestyle (predominantly eating and physical activity).
Exposure	Stories where women find hospital spaces alienating (e.g. lack of privacy) and feeling of exposure during inpatient hospital care, restrictive visiting times, feeling abandoned or unsupported. Also includes stories where women feel they are not being supported in mobilising their bodies. Prominent in these stories is the emotional exposure women feel as first-time mothers, especially when they are not supported to care for newborn infants following medical procedures which leave them immobile.
Doing what they recommend	Links with reproductive citizenship. Embodied maternal responsibility in action as is seen in stories where women draw on biomedical risk discourse to explain why they made decisions relating to clinical interventions.

Table 6.2 Obstetric stories and narratives

Theme	Description
Taking responsibility	Stories where responsibility and blame are central to the story's conflict. This theme highlights the overt and subtle ways that women are held responsible for their situation, and also the practices which help to communicate obstetric disapproval to the women.
Ignorant women	This theme highlights the ways obstetricians understand the origins of women's obesity, primarily through the lens of neoliberalism in stories which cast women as lacking in basic knowledge about 'healthy eating'. This theme also brings sharply into focus the ways that obstetricians maintain their own bodies and how they contrast their own practices with what they imagine larger women do or neglect to do. Larger women's capacity to parent is bound up with this positioning, and in some cases women are positioned as potentially incapable of raising a child due to immobility, or the knowledge to feed an infant appropriately.
Body as barrier to the foetus	Stories where women's bodies are constructed as risky, failing, or as barriers to accessing the foetus. This theme includes stories about moving or positioning women's bodies along with trying to see, feel, hear and reach the foetus. Stories in this theme also bring into focus the ways that larger

	women's bodies pose a risk to the foetus and the obstetrician (rather than the larger women herself). Stories in this theme also highlight a fear of shoulder dystocia which is represented as a potentially catastrophic complication. Talking about embodied largeness also poses a barrier for obstetricians: in that raising the topic of obesity is risky in itself, and sometimes causes defensiveness and withdrawal of women's co-operation in agreeing to medicalised screening, monitoring and procedures which has implications for the obstetrician.
Fatness as socially contagious	Stories whereby fatness is viewed as a contagion and therefore, spreading across the obstetric population and also to the next generation. This theme highlights the framing of obesity as a new 'norm' and the ways that obstetricians resist the normalisation of obesity in their conversations with women by drawing attention to the ways that fat hinders their work, and the ways equipment is used or withheld to make reference to the 'abnormality of 'maternal obesity'.

Table 6.3 Midwifery stories and narratives

Theme	Description
Educating women about eating/talking about weight	This theme contains stories depicting the ways that women are positioned by midwives, illustrating how midwives view women as lacking in knowledge about nutrition. The theme also relates to the ways midwives approach discussions about eating or BMI - in stories within this theme women are often infantilised.
Body as barrier to the foetus	This theme contains stories about how larger women's bodies are viewed as a barrier to the foetus and as generally unwieldy and difficult to move (the theme includes: mobility; conducting examinations such as blood pressure monitoring; and monitoring the foetus using touch, sound and sight).
Fatness as socially contagious	This theme reflects the idea that obesity has become the norm. It overlaps with the obstetric theme but differs in that there is increased focus on health education in the midwives' stories.
Fat, fit and healthy	Stories about the ways midwives' experience leads them to question the validity of the BMI as a useful way to categorise women's bodies in the context of pregnancy.
Taking responsibility	The ways midwives view women as failing to take responsibility for maintaining their weight within acceptable limits. This theme also contains stories about dealing with larger bodies in operating theatres and postnatal wards demonstrating how moving and handling of larger bodies is a contentious issue.

The label of maternal obesity	The ways that midwives see the label of 'high-risk' as playing out in larger women's pregnancies. This theme includes the provision of information about the expectations obstetricians have about the course larger women's pregnancies are expected to take.

Table 6.4 Anaesthetists' stories and narratives

Theme	Description
Risk	The risk that larger bodies pose to the anaesthetist and the ways that risk is communicated to the women at the *High-risk Anaesthetic Counselling Clinic*.
The new normality	Larger women's bodies as barrier to the foetus and the need to learn advanced skills to deal with larger bodies, particularly in relation to accessing the interior of women's bodies.
Taking responsibility	This theme is similar to the midwifery and obstetric theme in that the theme captures the tensions around who should be held responsible for the woman's current situation and the difficulties experienced by the anaesthetist.

6.1.1 Construction of monologues about early pregnancy

In analysing the women's stories about early pregnancy, I was keen to understand their experiences holistically. I recognised that the women's experience of pregnant embodiment could not be isolated from their wider experience of their bodies. Having experienced difficulties with becoming pregnant myself I was aware that I was drawn to aspects of the data in which the women expressed worry about becoming and staying pregnant. My own experiences made me more aware of stories where the women talked about being hypervigilant about early pregnancy embodiment. I felt a deep sense of empathy for the women, identifying with their need to have a baby and also their concerns about whether their body could support a pregnancy. These very personal experiences, and the prominence and salience of the women's stories about early pregnancy, guided my analysis and commentary on these experiences.

As I discussed in the previous chapter, when I constructed monologues from the MHP analysis I aimed to represent prominent themes from the categorical content analysis of the analysed stories. I also tried to select stories which 'spoke' to the women's experiences, providing further context to the issues captured in the stories. In analysing the MHP data I was aware that my previous experience as a public

health nurse had made me somewhat critical of the notion that providing people with information necessarily leads to modified lifestyles and improved health. I also had first-hand experience of how these very neoliberal practices made for awkward consultations.

When analysing the community midwifery data I was particularly struck by the intensity of the midwifery focus on providing women with information during early pregnancy. I strongly resonated with the midwives' stories about 'information-giving' as they reminded me of the times when I provided the parents of larger embodied children with leaflets instructing them on how to feed their children. While I could recognise similar practices to the ones I had previously been involved in, I also noted that, although the midwives felt duty bound to discuss the risks of larger embodiment, their stories also demonstrated distinct differences in the positions they took in relation to the larger body. During my time as a previous public health nurse I had not considered how my own embodiment and weight management strategies shaped my practice.

In this chapter I try to communicate findings which depict the complexities of providing women with information while simultaneously offering emotional support. I draw together stories into monologues which demonstrate how some midwives uncritically viewed their role as helping women to address lack of knowledge about eating. I also try to tease out further how MHP embodiment shapes their approach to this aspect of their practice. The monologues also aim to capture the scepticism some midwives felt about some of the technologies forming aspects of their practice (i.e. BMI charts and gestational diabetes screening). I also try to illuminate the how this scepticism is experienced in relation to current screening guidelines. My overall aim is to interweave the women's and MHP stories in monologues from alternative perspectives while retaining the uniqueness and complexities of participants' experience.

The titles of the stories (which are all verbatim quotes) and the themes contained within these stories are presented in the tables which accompany each monologue. The commentaries which follow, where relevant, also draw attention to aspects of the participants' experience which resonate with other participants.

Early pregnancy community care

6.2 Monologue 1- Kacey: feeling around the edges

Right in the middle of planning my wedding I find out I'm pregnant! This isn't my first pregnancy; I had a miscarriage a couple of years ago when I was in another relationship. After that relationship ended I worked really hard and managed to get my weight down. I was quite slim and I felt more confident, well, better than I felt during my childhood; you know how horrible kids are? I've always been big, so it was nice to be slimmer. I met Craig and all was going fine, I managed to keep the weight off, but then I started having terrible mood swings and headaches, and I was bleeding all the time. So they changed my pill and all the weight I'd lost just piled back on again. You know this can happen with the pill, but I wasn't expecting all the problems I had with craving sweet stuff. I used to ask Craig to drive me to buy chocolate late at night, my body felt out of control. They told me to come off the pill and use condoms instead, just to tide us over until after the wedding.

Even before the miscarriage I had this deep fear that I wouldn't be able to have children. I don't even know where it came from, and I suppose having a miscarriage didn't help that. It was like a deep uneasy feeling that I couldn't seem to shake. Anyway, after coming off the pill I did suspect I was pregnant, but I hardly dared to think that it might be true. It was quite weird, like a struggle between what your body's telling you, and a fear of letting yourself believe that it might actually be happening. I did 5 pregnancy tests in the end, just to make sure. The first ones I did were negative. But by 5 weeks there was a faint line. Craig's family said: "it's too early, anything can go wrong, so don't get your hopes up". But my family were really excited and my mum told everyone. I wasn't too happy about that because you're not meant to tell anyone until after 12 weeks.

Even when I phoned my GP practice I still believed there was nothing there, but they just told me to make an appointment with the midwife. The midwife sent me to the hospital for a scan and there it was, a tiny movement on the screen. I could hardly believe there was something in there. I cried. It was relief really.

The scan was just the beginning. Once I knew I was pregnant I just worried all the time. Those first weeks were a bit of a nightmare to be honest. I was convinced that I would do something wrong, that something would hurt the baby. I'd been told not to lose any weight but I did lose weight in the beginning, I couldn't keep anything down. Of course I put it all back on again and now I'm worried about what size I'll be at the end.

Table 6.5 Kacey: feeling around the edges

Narratives drawn on in this monologue		
Participant	**Title**	**Theme**
Kacey	*Seeing is believing*	Seeing is believing
	Anything can happen	Anything can happen
Stories drawn on in this monologue		
	Title	**Theme**
Kacey	*The long awaited pregnancy*	Seeing is believing
	I didn't believe it	Seeing is believing
	It's early days, so anything can happen	Anything can happen
	Piling on the weight	The struggle for control
	Seeing is believing	Seeing is believing
	I don't know what you're allowed to do	Anything can happen
	BabyGaga	Anything can happen
Motif		
Feeling around the edges		

6.2.1 Commentary and discussion

Body as flux

Pregnancy is often discussed as a time when women may feel a sense of loss of control over their bodies (Warren & Brewis, 2004), However, my analysis revealed that Kacey framed her experience of pregnant embodiment in the context of a lifelong struggle with containing the size of her body. I noted that her stories about the menstrual problems she experienced while using oral contraceptives characterised a body which was unpredictable (Grosz, 1994; Warren & Brewis, 2004) and leaky (Shildrick, 1997). Furthermore, I considered that perhaps Kacey's

previous miscarriage was perhaps also an aspect of this struggle, in that there was little she could do to prevent the foetus being expelled from her body.

Previous research has suggested that prior to pregnancy women may experience their bodies as "malleable and pliant" (Warren & Brewis, 2004: p.226). However, in contrast to this assertion I found that Kacey and the other participants experienced their bodies as in a constant state of flux (Grosz, 1994); characterised by change and unpredictability involving a high degree of emotion work. This is an aspect of embodiment, which has been discussed within sociological literature, but is rarely acknowledged in healthcare literature.

Overall, I noted that Kacey's stories depicted a body which she framed as making demands which were hard to understand and resist. In this respect I suggest that her body may be best described as a body which at times "slips its moorings" (Warren & Brewis, 2004: p.221). Furthermore, it appeared that Kacey's experience of embodiment provided a compelling counter-narrative to the Western belief that we can manipulate our bodies, that we do not simply possess or control our bodies (Aalten, 1997; Featherstone, 2000; Warren & Brewis, 2004). Therefore, the biomedical framings of 'obesity', which I discussed in Chapter 3, seemed to bear little resemblance to her experience of embodiment.

I also found that other participants experienced their bodies as anything approaching "malleable and pliant" (Warren & Brewis, 2004: p.226) in that they described experiencing a lifelong struggle with weight-related issues. For example, I noted that Angie's interviews were characterised by stories about how hard she had worked to make her body smaller through dieting and exercise (unsuccessfully) (see Appendix 22). On this matter she commented: "I've been tarred with the obese brush since I was about 13 or 14, which is not much fun". This finding echoes that of Heslehurst *et al.* (2015) who found that larger women had experienced childhood and adulthood acutely aware of their larger size, and were well familiar with practices designed to reduce their adiposity such as dieting.

I also found that some of the women also experienced medical conditions which are believed to be associated with weight-management problems. Susie for example, had

been diagnosed with polycystic ovary syndrome[48] (PCOS) as a teenager and had experienced lifelong weight-issues. After several years of trying to conceive she was on the waiting list for fertility treatment at the time she became pregnant. Vron had also been screened for PCOS at her request after her menstrual cycle stopped and she developed other symptoms which could indicate the presence of this condition. She was expecting the results of blood tests when the doctor informed her that the reason her menstruation had stopped was because she was pregnant.

Healthcare literature suggests that 40% of women with PCOS experience problems with managing their weight which may be due to the effects of insulin resistance[49] (Balen *et al.*, 2006). I found that Susie and Vron had both received screening for PCOS, however Murray (2009) and Kwambai (2014) argue that when it comes to gaining medical support in dealing with the weight-management issues associated with PCOS often this is not forthcoming. It was not clear what support Susie had received in managing the effects of this condition. However, she had been advised that unless her BMI was under 30kg/m^2 she would not be eligible for fertility treatment. Preventing women with 'obesity' from accessing NHS fertility services has generated discussion in medical circles who argue that the risks of maternal obesity make pregnancy inadvisable (e.g. Balen *et al.*, 2006). Susie's experience reflects the current policy enactment of a recent UK infertility guideline (Scottish Government, 2013) which recommends that "a normal BMI is best for both partners" prior to embarking on fertility treatment. I will discuss this aspect of the analysis further in Section 7.6.

Body as infertile

The stories Kacey told me about discovering she was pregnant also revealed a deep-rooted fear of infertility. I noted that the other women all described discovering the pregnancy in the context of a conviction that they would experience difficulties with

[48] Polycystic ovary syndrome is associated with irregular menstrual bleeding, excessive body hair, weight-gain, skin problems and the presence of multiple fluid filled sacs on the ovaries. It is a condition of unknown aetiology but is believed to be related to a hormone imbalance which causes an increase in the levels of insulin (which regulates the use of sugar in the body). As PCOS is associated with irregular or absent menstruation women affected by this condition may require medical intervention to assist them in becoming pregnant (NHS Choices, 2016b).

[49] Insulin resistance is associated with higher levels of insulin which regulates appetite and weight distribution on the body (NHS Choices, 2016b).

conceiving. Further examination of the interview text also revealed that although all the other participants expressed a fear of infertility, with the exception of Vron and Susie, none were able to identify the source of their anxieties.

At the time of the interviews I made the assumption that perhaps the participants had been exposed to web-based health information (e.g. NHS Choices, 2007) linking adiposity with various health and social ills, including infertility. But further analysis revealed there was nothing in the women's talk to support this. I was aware that the women might have elected to deny knowledge about this framing of the larger body. However, as they were all open to talking about how they felt about their (larger) bodies, I wondered if there was another explanation.

At the time Vron, Nicola, Angie and Kacey became pregnant none of them were planning to conceive. However, they had also been using oral contraception somewhat sporadically, suggesting that they were perhaps happy to risk becoming pregnant. Granzow (2007) suggests that women taking oral contraceptives may be suspicious about how this type of medication acts on fertility: especially as women are advised that their fertility levels may be lower immediately after discontinuing their use. Similarly, Gonçalves *et al.* (2011) argue that this type of information may evoke distrust in oral contraceptives. Therefore, I considered that perhaps the participants' 'relaxed attitudes' towards contraceptives may have been shaped by a curiosity about their fertility related to oral contraceptives.

Confirming the pregnancy and the precarity of early pregnancy

My analysis also revealed that Kacey's stories about early pregnancy were characterised by two prominent narratives which were also found across all the women's data: 'seeing is believing' and 'anything can happen'. 'Seeing is believing' relates to the situation whereby a reliance on data from biomedical technologies is valued over embodied sensations (in terms of confirming and reconfirming the viability of the pregnancy). Whereas, 'anything can happen', refers to the notion that early pregnancy is fraught with risk, unpredictable in nature, and therefore, the developing foetus can be lost at any given moment. I found that Kacey drew on these narratives to frame her stories of early pregnancy; demonstrating how the uneasy

feelings she had about fertility gave way to feelings of disbelief that she had become pregnant and then to tentativeness about early pregnancy.

Seeing is believing

Davis (1995) suggests that, in the context of pregnant embodiment, visceral sensing is often disregarded as a source of knowledge along with women as 'knowers'. I certainly found that external data from biotechnologies were positioned as more authoritative than visceral sensory experience. I noted that once the women's pregnancies were confirmed, disbelief that conception had occurred gave way to a need for frequent reassurance that the pregnancy was developing normally. These feelings left the women feeling they had little control over their pregnancies, exacerbating their need to confirm and reconfirm the viability of the developing foetus.

Ross (2015b) suggests that tentativeness in early pregnancy also relates to perceptions of risk with respect to miscarriage, and the need to keep the pregnancy a secret until a stage when this risk has passed. She also notes that early experiences of pregnancy may generate feelings of uncertainty and ambiguity due to the absence of visual signs of pregnancy (such as a 'pregnancy bump'). Previous research with larger women has highlighted that, due to increased adiposity, larger women may have reduced awareness of foetal movement (Stacey *et al.*, 2011). Therefore, in the absence of visual or other sensory data women often rely on a heightened engagement with various medical technologies which provide both numerical and visual data to evidence the continuing viability of the pregnancy (Ross, 2018). In this respect I found that all the participants sought reassurance through engagement with biotechnologies carrying out: repeat home pregnancy tests; requesting additional pregnancy testing in healthcare contexts; and through 'seeing the baby' via ultrasound technology. Therefore, these forms of biotechnologies were important to women in terms of confirming the presence of the foetus and monitoring its on-going normal development (Harris *et al.*, 2004).

It is important to note that, although I found that obstetric biotechnologies were highly valued by the participants, modern technologies have also been criticised as eroding women's ability to relate to, and trust their own bodies (Katz Rothman,

1988; Duden, 1993). Furthermore, biotechnologies render women vulnerable to obstetric risk discourse and practices which are prominent in the risk society (Lupton, 2012c, 2013c). As I will demonstrate throughout the findings of this research, technologies of foetal growth monitoring and screening for GDM act as a form of institutional disciplinary power (Foucault, 1995) creating a troubling situation for the participants especially during the later stages of their pregnancies.

Anything can happen

I suggest that my findings strongly resonate with previous research on early pregnancy which suggests that women may feel tentative about the viability of their pregnancies until the end of the first trimester (Ross, 2015b). With regards to feelings of tentativeness, Katz Rothman (1988: p.103) describes early pregnancy in terms of how women "keep a distance, emotionally and pragmatically, from the baby" until the foetus is deemed to be developing normally. In the current research I noted that participants described various strategies for creating an emotional distance between themselves and the foetus. Anna for example, told a story in which she had named the foetus 'The 3-headed Dragon' in the weeks leading up to her first ultrasound scan, and 'Froggy' thereafter. On this matter she said, "I think calling the baby 'The 3-headed Dragon' or 'Froggy' is my way to cope if anything were to happen, I'm not calling baby 'baby'. So maybe it's like a coping mechanism".

Kacey's stories also revealed that the concerns she had in early pregnancy appeared to be further heightened by her close family members, who reminded her about the risk of early miscarriage prior to 12 weeks gestation. The '12-week rule' according to Ross (2015a) is a notion proffered in the healthcare information provided to pregnant women, which advises them not to tell others about the pregnancy until the risk of early miscarriage has passed (e.g. NHS Health Scotland, 2012). As will be revealed in a later monologue in this chapter, the 12-week rule can be problematic for some women due to the need for secrecy which may increase feelings of loneliness for some women (see Sections 6.2, 6.7 & 6.8).

Analysis of Kacey's stories revealed that once she was satisfied of the existence of the foetus her concerns shifted to an uncertainty about what her body can and can't do in pregnancy. As I discussed in Chapter 3, feelings of uncertainty and a need to

find information can be characterised as a facet of the risk society (Giddens, 1990; Beck, 1992), demonstrating a reliance on external advice from 'experts' which has been well documented within social science literature as a feature of neoliberal societies, in relation to motherhood (e.g. Murphy, 2003), pregnancy (e.g. Possamai-Inesedy, 2005; Ross, 2015b, 2018), and infant feeding (e.g. Lee, 2007; Keenan & Stapleton, 2010). Kacey's concerns demonstrate how she grapples with the uncertainty of early pregnancy (Ross, 2018), and in many respects she seems to be 'feeling around the edges' in terms of her body's capabilities, and this corresponds with what she should and shouldn't do as a pregnant woman. I found that Kacey's concerns were a prevailing motif across the research data and I will discuss this finding in more detail as the chapter progresses.

So far in this chapter I have presented and discussed findings which suggest that, in the early stages of pregnancy women were involved in a high degree of emotion work. I have also drawn attention to the women's need for reassurance from medical experts and biotechnologies (Ross, 2015b, 2018). In the following 2 monologues the focus shifts to analysis of early pregnancy care which was captured in interviews with 2 community midwives: Emma and Lesley.

6.3 Monologue 2 – Emma, community midwife: the new guidelines target women

I've never been slim myself. And I've struggled with my weight. So I think this helps me to talk to overweight women. It's a good thing really, with all the fuss being made about high BMI women these days. With the new guidelines, we have to tell everyone with a BMI of over 30 to take an increased dose of folic acid. A*nd* also tell them about the additional screening for gestational diabetes. And all this at the first visit, when we're trying to develop rapport with them!

I mean, some women with a BMI of 30 just look in proportion: it's not like they're rolling with fat. So sometimes I look at these women and think, "how am I going to tell you that you're classified as a high-risk pregnancy?" So really, I feel the new guidelines target bigger women. They make assumptions that big women are going to develop gestational diabetes because of their size, when in fact slimmer women

get it too. Bigger women who had a baby a few years ago weren't classed as high-risk. So when they come back they can't understand why they need these additional screening tests, so it just looks like we're making a fuss when we don't need to.

So it's a pretty delicate situation, because you're always aware of how women might react. But I think women confide in me because they know I'm not going to give them a telling off. Which is just as well as a big part of my role involves talking to women about what they should and shouldn't do in pregnancy. So I need to have an idea of what they know, and what they're up to. It's really all about what's best for the woman and her baby. And that's where my professional knowledge comes in. I say to them that I realise how difficult it can be to make changes in your lifestyle, and I think they look at me and know that I've struggled too. I always reassure them that it's all about finding a balance, so they're not scared to confess that they've had a bad week and eaten too many doughnuts, or smoked 10 cigarettes.

Table 6.6 Emma, community midwife: the new guidelines target women

Narratives drawn on in this monologue		
Participant	Title	Theme
Emma (community midwife)	*Empathy, honesty and the confessional*	Educating women about eating/talking about weight
Amy (charge midwife, labour ward)	*We can't risk our relationship with women by talking about weight*	Fat, fit, and healthy
Amy (charge midwife, labour ward)	*Fat, fit and healthy*	Fat, fit, and healthy
Stories drawn on in this monologue		
Participant	Title	Theme
Emma (community midwife)	*What's best for you and your baby*	Educating women about eating/talking about weight
Jodie (midwife)	*It's just a number*	Fat, fit, and healthy

6.3.1 Commentary and discussion

When I interviewed Emma, I was firstly stuck by two aspects of her practice which she positioned in her stories as being in opposition to each other. Firstly, was her scepticism about gestational diabetes screening (which she was obliged to explain to larger women). And secondly, was her desire to support women without appearing to

judge them. I noted that Emma's stories foregrounded the strategies she used to form the type of relationship she felt the women would experience as supportive. Her stories demonstrated that one such strategy was to reveal aspects of her own embodiment as means of signalling to the women that she understood their experiences. In these stories she characterised her relationship with larger women as being one which would also support her role in providing women with information about the risks of larger embodiment in a manner which women would accept.

In Kacey's monologue I presented findings which demonstrate the way that the women positioned biotechnologies in the context of early pregnancy. My discussion now shifts to consider how midwives framed and understood the role of technologies in relation to current care guidelines and practices involved in the care of larger women.

Targeting women: fat, fit, and healthy

I found that the theme 'fat, fit, and healthy', was highly prominent across all the midwifery interviews. One of the aspects of midwifery practice illuminated by stories and narratives related to the difficulty midwives expressed in raising the topic of GDM screening with women who do not appear particularly overweight. Further analysis of this data revealed that when midwives raised concerns about this issue, they tended to relate their concerns to the fear of upsetting or offending women by raising weight as a potential complication during pregnancy.

Emma's stories revealed that she critiqued the blanket screening of women with BMI $\geq 30 kg/m^2$ (CMACE/RCOG, 2010) due to the anticipation that few larger women develop GDM. Her positionality in these stories suggested that she viewed this guideline as unnecessary targeting of larger women. My analysis also revealed that, although she was obliged to discuss GDM screening with higher BMI women she found this conversation problematic in that it involved raising the topic of 'obesity' with women who are not what she considered 'obese'. While I noted that Emma's concerns were based on her own experience of conducting GDM screening in the context of maternal obesity policy, my analysis suggests that she perhaps unknowingly, draws on a less prominent counter-discourse which identifies various

problems with the utilisation of BMI as an indicator of 'abnormal' or 'unhealthy' body adiposity (e.g. Janiszewski, 2012).

Targeting women: the confessional

The analysed midwifery stories also suggested that when midwives were obliged to raise the topic of weight with women, they tended to focus on the importance of discussing lifestyle issues. This aspect of the analysis also illuminated that midwives who self-identified as 'overweight' often used what they described as an 'empathic approach' based on their own embodiment to align themselves with women and encourage them to 'open up' and disclose information (Zhu, Norman & While, 2011). Emma's stories about talking to women in the clinic revealed that she positioned herself as somewhat jovial and matriarchal as she felt this would support her aim of gathering information about women's lifestyles. I suggest that her method can be understood as providing a confessional space (Foucault, 1978). As I discussed in Chapter 3, feminist literature highly criticises this approach as it tends to infantilise women (e.g. Rúdólfsdóttir, 2000): positioning midwives as 'expert' and women as 'passive' receivers of care, making for relationships which are far from equal (Wray & Deery, 2008).

My analysis revealed a somewhat darker side to the so-called 'empathic relationship' midwives sought with women. In fact, I suggest that the relationship the midwives sought to create was in fact expected to encourage women to confess deficit knowledge and behaviours. Furthermore, the midwifery stories also revealed that by gaining access to personal information about the women's lifestyles allowed them to correct misinformation, provide advice, and make referrals (e.g. to the dietician). On one hand encouraging women to divulge information may be viewed as a necessary intervention: legitimising the value of the confession. However, I want to suggest that as I found that the midwives tended to draw heavily on mainstream anti-obesity discourse, they provided a narrow frame within which the women could be understood (see Monologue 3). Therefore, I suggest that this type of confessionary space may serve as a means for perpetuating mainstream obesity discourse by failing to allow for alternative understandings of larger embodiment. I further suggest that this situation further marginalises larger women's experience and knowledges (Colls

& Evans, 2009; LeBesco, 2011; Monaghan, Colls & Evans, 2013). Therefore, what Emma identifies as targeting larger women may have far reaching consequences extending beyond what she herself articulates in her stories. This point is further illustrated in the next monologue.

6.4 Monologue 3 - Lesley, community midwife: getting out the special pink leaflet

When I was first a midwife in 1997 it used to be a real shock when someone with a big BMI came in. But now it's every third or fourth person, and we've had to get new beds and wheelchairs and everything. I blame junk food, and often I'm shocked at the general lack of knowledge that some women have about eating properly. Like this woman I booked a while ago. Her BMI was 45, and so when she came for her second visit I got out my special pink leaflet: the one that tells you how to replace unhealthy foods and drinks with healthy ones. It's really brilliant and I use it along with the *Ready Steady Baby!*[50] book to help me explain healthy eating to them. Anyway, this particular woman thought she was doing well. She'd swapped her 2 litres of full fat coke for 2 litres of fresh orange. I mean she had absolutely *no* idea what she was doing and I thought, "you'd be better sticking to the coke!"

She thought it was healthy you see, and she's not alone, I get a lot of Indian and Pakistani women who eat rice three times a day and think that's healthy. It's *shocking* the amount of carbohydrates some people eat, so I tell them to cut down on the rice and increase the chicken. It's a shame more of them don't watch these programmes on the telly, the ones that tell you the secrets behind the food we eat. So with big women, a lot of it is about educating them. It's a bit hit and miss though, and sometimes they shut off, but others are quite open to it. I think a lot of them don't realise how heavy they are until I weigh them and then the penny drops! But I think some of them aren't interested in watching their weight when they're pregnant, they just think they're going to put on weight anyway. But when the bigger girls lose weight it's usually because they're watching what they eat.

[50] *Ready, Steady Baby!* is a free resource distributed by midwives to pregnant women. It is funded through NHS Health Scotland and provides information about pregnancy, childbirth and parenting (see http://www.readysteadybaby.org.uk/index.aspx).

I've never had any problems with my weight, and I don't even know what my BMI is, so I'm never very sure how to talk about size. I think the best way I've found is to wait until they describe themselves, and then I use the same terms. They might say, "cuddly" or, "there's a bit more of me". I don't use obese, I think it's a horrible word. Being careful about what I say helps, especially as we've got to weigh them. I get a lot of scale dodgers. The good BMIs don't mind standing on the scales, they're the ones who've always watched what they're eating. But the one's that know they've put on too much are always pleading to avoid the scales, saying, "must we?" So they know they've put on too much. I think some of them eat for two or spend their maternity leave sitting around eating, and then they're keen for me not to tell their partners what they weigh. They get embarrassed, especially about the size of their breasts, which I think stops a lot of them breastfeeding: they can't imagine ever being able to breastfeed in public. Anyway, it's always the ones who haven't put on too much that want to stand on the scales, and I'll say to them, "oh wow, excellent! You've only put on 5, or 6, or 10 kilos". They're my good BMIs. With the ones that have put on too much, I tell them to cut down what they're eating for the next couple of weeks.

The bigger girls tend to get bigger with each pregnancy, and by the time they come for their third they've put on about 30 kilos. It tends to run in families too. I've got a 19 year old just now who's got a BMI of 45, so she didn't get like that overnight. I blame all the fast food we have in this country: chip shops, kebabs, pizzas, deep fried pizzas, deep fried mars bars, all washed down with a diet coke to make us feel better. It's not like that in other European countries. But actually people are just lazy, you know: going to *Farmfoods*[51] and buying something that you can stick in a deep fat fryer, or in the oven. They think it's better than going to the supermarket and buying mince to make a nice chilli con carne with a wee bit of rice.

Table 6.7 Lesley, community midwife: getting out the special pink leaflet

Narratives drawn on in his monologue		
Participant	Title	Theme

[51] Farmfoods is a frozen food supermarket chain based in the United Kingdom.

Lesley (community midwife)	*Getting the flesh out*	Women's bodies as a barrier to the foetus
Lesley (community midwife)	*Getting bigger*	Fatness as socially contagious
Lesley (community midwife)	*Running in the family*	Fatness as socially contagious
Lesley(community midwife)	*A nice chilli con carne and a wee bit of rice*	Educating women about eating/ talking about weight
Amy (charge midwife labour ward)	*Women don't realise what they're eating*	Educating women about eating/ talking about weight
Stories drawn on in this monologue		
Participant	Title	Theme
Lesley (community midwife)	*The girl who gave up – Parts 1 and 2*	Educating women about eating/ talking about weight
Lesley (community midwife)	*It's just educating them – Parts 1 and 2*	Educating women about eating/ talking about weight
Lesley (community midwife)	*Bringing out the special pink leaflet*	Educating women about eating/ talking about weight
Lesley (community midwife)	*Standing on the scales*	Taking responsibility
Lesley (community midwife)	*We don't worry about the bigger girls losing weight*	Educating women about eating/ talking about weight

6.4.1 Commentary and discussion

Educating women

Analysis of the community midwifery data revealed the ways they drew on their own experiences and practices of weight-management, revealing how they made sense of embodied largeness. Lesley's stories revealed that she positioned herself as 'unaware of her actual BMI', and of 'never having a weight-problem'. Analysis also revealed that she firmly drew on the energy balance model (Gard & Wright, 2005) of mainstream obesity discourse in stories about her conversations with larger women. In doing so it was also notable that she neglected the sociopolitical and cultural influences on BMI which are believed to be equally important (Danielsdottir, O'Brien & Ciao, 2010; Puhl & Heuer, 2010). Further analysis revealed her talk demonstrated a position on 'obesity' firmly situated within a neoliberal framing which holds individuals as responsible for addressing knowledge deficits in relation to health improvement (Lupton, 2013a).

As I discussed in Section 2.9.6 (Thorny issue: 4), existing literature suggests that MHP often view larger women through a deficit model which questions larger women's knowledge about nutrition (Knight-Agarwal *et al.*, 2014), their ability to cook (Furness *et al.*, 2011), and self-care (Carryer, 2001). My analysis of the midwifery data also suggested that a deficit model framing was drawn on in criticising larger women: serving to justify some of the intolerance some MHP felt towards them. I noted that, as with Emma's stories, my analysis of Lesley's stories also revealed that she took a somewhat hierarchical approach to her relationships with women (Wray & Deery, 2008). The most notable of these were stories about the 'special pink leaflet' and the 'scale dodgers', which tended to reduce women to a childlike status (Rúdólfsdóttir, 2000). This type of approach has been highly criticised for compounding the difficulties larger women have in managing their weight (LeBesco, 2011).

Fatness as socially contagious

Monologue 3 also introduces the theme of 'fatness as socially contagious' which I found was a strong and pervasive narrative running throughout the MHP data and formed the rationale for the need to educate larger women. This narrative resonates somewhat with Schmied *et al.*'s, (2011) finding that 'obesity' in the obstetric population has gradually increased through a process of 'creeping normality'. I noted that, in this respect, the MHP suggested they believed fatness had become socially contagious. Further my analysis illuminated that, although the MHP were more familiar with providing care to larger women, their stories and narratives demonstrated little acceptance towards larger bodies. In fact, it was notable that the women were most often positioned in stories as 'deviant bodies' (Foucault, 1995) who had been unknowingly 'infected' by a new social normality (a fatter body than in previous decades). According to this narrative, due to the large number of people within their social circle with larger bodies, women are failing to *notice* they are 'overweight', and therefore, require educating. This framing somewhat mirrors earlier research, which suggests that health professionals understand the origins of embodied largeness as "socio-ecological" (e.g. Greener, Douglas & van Teijlingen,

2010: p.1042), as the result of obesogenic environments[52] (Smith & Cummins, 2008). However, my analysis of MHP stories suggests that, although some MHP may draw on broader cultural understandings relating to embodied largeness, invariably they tended to focus on individual factors such as diet and exercise. Furthermore, it appeared that conversations about diet and exercise formed an important means by which MHP *alerted* larger women to the fact they had become infected by obesity: through seeking to identify deficits in the women's knowledge about eating and physical activity, with the aim of educating them.

Existing literature demonstrates that MHP may have an expectation that the healthcare practice of 'information-giving' in the context of 'maternal obesity' will enable behaviour change (e.g. Heslehurst *et al.*, 2013). My findings also demonstrate that the midwives seemed to share this expectation. It was clear from Lesley's stories that she believed that by providing 'expert' advice larger women will act on this advice: becoming complicit in the governance of their body mass (Miller & Rose, 1990; Rose, 1990). Lesley, therefore, has a focus on educating women about 'appropriate weight', remedying their misconceptions about what they should weigh and should or shouldn't be eating.

I also noted that Lesley's stories drew on recent public health discourse relating to type 2 diabetes in that she pinpoints high carbohydrate diets as particularly problematic (e.g. NHS Choices, 2016b). Her talk may reflect the latest guidelines which have been highly publicised by the media due to the significant shift in the advice given to the public: from recommending low fat diets, which are now claimed to be making people fat (Connor, 2015), to the current advice to eat a low carbohydrate diet (Richards, 2015).

Medical equipment and the Othering of larger women

I suggest that Douglas' (1992) writing on the Othering of social groups who are perceived as a threat, may be helpful in shedding light on the Othering of larger

[52] According to Smith and Cummins (2008) the concept of "obesogenic environments" has its roots in the socio-ecological model and describes the impact of the physical environment, economic environment and the socio-cultural environment on the balance of energy within the body, creating more larger people.

women particularly by ‘slimmer’ MHP, who draw on neoliberal notions of responsibility and blame in relation to body adiposity. Lesley, like other MHP, used narrative to draw attention to her disapproval about the need to provide specialised equipment for larger women. It is unlikely she would directly express her views to the women in her care (Swift *et al.*, 2013), however I found the stories told by MHP revealed the more subtle ways they drew attention to embodied largeness as an ‘abnormal’ condition.

In particular, I noted that, although some of the midwives (most often larger midwives) appeared conscious of avoiding ‘targeting’ women (see Monologue 2), most MHP described using various means of drawing attention to the ‘abnormality’ of larger women’s embodiment. The most obvious means of doing this relied on the use of medical technologies such as BMI charts, referral forms, or scales, and by ‘educating’ them how to become smaller. While midwives had a focus on lifestyle issues, I found that obstetricians tended to draw on risk discourse to Other larger women, a practice some midwives found very problematic. This finding is presented in a later monologue when we revisit Emma, the community midwife when she narrates a story about the ways she views risk discourse as acting on larger women’s pregnancies. In the next monologue I continue with the discussion about how biomedical technologies act in the context of larger women’s MHC.

6.5 Monologue 4 - Emma, community midwife: we need to take a balanced approach

It can be really hard work supporting high-risk women in the community, especially when obstetricians are always talking to them about the worst-case scenario, which I think just plants a seed in women’s heads. Talking about this reminds me of a woman I had last year. She’d lost a stone before this pregnancy but her BMI was still 55. She had a miscarriage in her last pregnancy and blames her weight. I think she read that high BMI causes miscarriage: that can’t be an easy thing to live with. When she found out that she was pregnant again she was worried she was going to have another miscarriage. So she was pretty anxious. But not as anxious as she was after she’d been to the antenatal clinic to see the obstetrician. They told her there was no way she was going to have a normal birth, in fact they were extremely negative about

the whole thing. She's a bright woman, a teacher, but she's had a bit of depression in the past. Anyway, I spent the rest of her pregnancy trying to reassure her: helping her get some balance. We had lots of hugs and tears, and sometimes I would get her smiling again only to have all this undone by the next visit to the hospital. It was really hard trying to support her through all that. She'd been a big woman all her life and I just felt that she should have had a bit more acceptance. It was hard to see her trying not to gain weight and wanting to be weighed all the time.

Some of the obstetricians are better than others, you know, it's not what you say, it's *how* you say it! Not all women have complications because of their weight, but I think some of them forget that, and all the obstetricians talk about is the worst-case scenario. When I talk to women about risk I'm always careful to stress that they *might* be at higher risk. Their care involves a bit of additional screening, and it doesn't mean that they can't return to my care, so I tell them, "if these tests come back normal, then we'll carry on the green pathway, you know: normal care". They're always relieved when I say that, and it helps to stop them Googling everything and getting really anxious.

Table 6.8 Emma, community midwife: we need to take a balanced approach

Narratives drawn on in this monologue		
Participant	Title	Theme
Emma (community midwife)	*Targeting women and placing ideas in their heads*	The label of maternal obesity
Stories drawn on in this monologue		
Participant	Title	Theme
Emma (community midwife)	*Taking a balanced approach – Parts 1 and 2*	Women's bodies as a barrier to the foetus
Emma (community midwife)	*The worst-case scenario: putting ideas in their heads*	The label of maternal obesity

6.5.1 Commentary and discussion

The label of maternal obesity, and the worst-case scenario

When analysing Emma's interview I noted that she critiqued the current approach to 'maternal obesity' by drawing attention to a key narrative utilised by obstetricians in

their consultations with larger women: 'the worst-case scenario'. I also noted that she utilised two stories within her interview to explain how the worst-case scenario negatively impacts larger women's experience of pregnancy, maternal identity, and maternal wellbeing. My analysis also suggested that she identified risk discourse (Possamai-Inesedy, 2006), as forming an increasingly prominent and problematic narrative in obstetric consultations with larger women. Her argument is based on the idea that risk discourse 'plants a seed': thereby altering women's expectations of their body's ability to support the pregnancy and deliver a healthy infant.

This aspect of the analysis was aided by looking carefully at the way midwives narrated their experiences in stories within the theme 'the label of maternal obesity'. By doing so I was able to see how midwives viewed the label of high-risk as playing out in larger women's pregnancies. I noted that when midwives were critical of current maternal obesity guidelines they framed the care women received as targeting larger women, calling for a more balanced approach. More specifically, I found that stories within the theme 'the label of maternal obesity', revealed that, whether midwives implicated the current approach to 'maternal obesity' as targeting larger women, depended very much on whether they understood women as deserving of blame or understanding. I found that when midwives positioned women as in need of understanding, they tended to work hard in trying to protect women's feelings, providing reassurance to balance or soften the impact of the effect of the obstetric worst-case scenario. Furthermore, I noted that whether MHP positioned women as being targeted by MHC maternal obesity policies, related very much to their own embodiment and experiences of weight-management. This aspect of the research is also represented in later monologues.

6.6 Monologue 5 - Emma, community midwife: getting out the big cuff

Although I don't think higher BMI women necessarily have more risk of GDM, they can have raised blood pressure, so we need to keep an eye on that. Taking high BMI women's blood pressure can be difficult though, especially when you don't use a cuff that actually fits. My pet hate is seeing other health professionals squeeze small BP cuffs onto big arms: *then* they wonder why all big women have raised BP! They

send all these women off to the hospital, causing undue anxiety and fuss, to get their BP checked needlessly. And all because they didn't use a cuff that fits. When I get out the obese cuff, actually it's like a flag, sometimes women say, "oh you're using a special cuff" and I just say, "I want an accurate reading, I don't want to be sending you in because the cuff's too tight". And they're usually fine with that.

Table 6.9 Emma, community midwife: getting out the big cuff

Narratives drawn on in this monologue		
Participant	Title	Theme
Emma (community midwife)	*Targeting women and placing ideas in their heads*	The label of maternal obesity
Stories drawn on in this monologue		
Participant	Title	Theme
Emma (community midwife)	*Taking a balanced approach – Parts 1and 2*	Women's bodies as a barrier to the foetus
Emma (community midwife)	*The worst-case scenario: putting ideas in their heads*	The label of maternal obesity

6.6.1 Commentary and discussion

The label of maternal obesity

This commentary forwards the theme 'the label of maternal obesity' which captures how some MHP framed this particular label as generating additional problems for larger women. Stories about ill-fitting blood pressure cuffs are common in medical and media discourse along with stories about larger people not fitting into beds, trolleys and chairs (e.g. Hope, 2012). This narrative tends to chastise larger people for additional cost to the NHS (e.g. Khan, 2015; Pickles, 2015). Midwifery literature has highlighted the difficulties midwives have in obtaining accurate blood pressure readings (DeJoy & Bittner, 2015; Foster & Hirst, 2014; Schmied *et al.*, 2011): often tending to frame the problem of ill-fitting cuffs as posing practical issues for midwives in busy clinics, especially when larger cuffs are not to hand (Cullum, 2009: p.367). However, I found that the provision, or withholding, of specialised equipment also revealed much about whether MHP wish to target or provide balance in relation to larger women's care.

I found that stories within the theme ‘fatness as socially contagious’ suggested that, when MHP wished to draw attention to increased adiposity, biotechnologies provided a means to do so. Emma’s stories however, revealed a desire to avoid drawing attention to the women’s embodiment by using well-fitting equipment. Emma achieves this by drawing on the narrative, ‘the label of maternal obesity’, which positions larger women as the targets of greater scrutiny with regards to complications including high blood pressure and pre-eclampsia in pregnancy. Further, her stories suggest that one of the ways she seems to seek to provide balance in relation to ‘maternal obesity’ is through using the big cuff, as she feels it provides a greater degree of accuracy in measuring blood pressure, (which she believes helps larger women to avoid additional medical attention). In order that any potential embarrassment is avoided, Emma takes a straightforward and direct approach position on using the bigger cuff, fending off questions and embarrassment by explaining that it will keep the woman from being unnecessarily referred to the obstetric team.

The provision of equipment for larger people is framed within the media in terms of giving in to the ‘obesity epidemic’ (e.g. Khan, 2015; Pickles, 2015). I found that the provision of equipment played a complex role in within stories throughout the journey through MHC: forming a key aspect in the ‘dance’ (Gee, 1999) of ‘maternal obesity’. The most obvious aspect of the role equipment played related strongly to notions of either targeting women or providing balance. This aspect of the analysis is more fully discussed in later monologues: demonstrating the more overt ways the communication of risk and the use of equipment serve to indicate to women the MHP position on ‘maternal obesity’.

In the next monologue I demonstrate how Nicola begins her engagement with the community midwife. The monologue depicts her trepidation in relation to accessing MHC and her initial engagement with ‘maternal obesity’ risk discourse.

6.7 Monologue 6 - Nicola: being in the spotlight

I was 8 weeks pregnant when I saw the midwife, so she did both the booking appointments at once, and it was a lot to take in. I was feeling really sick and dizzy at

the time so it's all a bit hazy. But I do remember I asked her about healthy eating and diet, not because there's anything wrong with what I eat, but because I'm bigger and I thought I should. I knew that there was a pretty high chance that she thought I was lazy or ate rubbish. I say I'm not bothered what people think, but I suppose being a bigger girl you're always in the spotlight.

It seemed ages until I got my first scan. I think at that time I felt really alone, which is not really like me. Time just seemed to pass so slowly. Part of me didn't want to have the scan in case there was nothing there, but I knew I had to go. I'm sure everyone feels a bit like that - you know, you hear people talking about how great it is to see the baby, how real it makes it, but I was so convinced that I wasn't going to be able to have children I was overwhelmed by it all. The sonographer had a trainee with her who did all the scanning, which was fine. They all seem to be training someone so you get used to that. She explained the whole scan to me and I was really emotional. It was such a relief, a relief that there was a baby in there kicking its legs around, and a relief that they were nice to me.

The community midwife said I'd have to see the doctor at the hospital antenatal clinic. So when the appointment came through I knew what it was. I wasn't too worried about the thought of them talking about my weight or anything; they feel they have to do it, and I think it's just something that I have to accept. The doctor told me that I'd need extra scans because the midwife wouldn't be able to tell if the baby was growing. I don't mind the thought of having extra scans though because they're so reassuring. She said I also need to have a pregnancy diabetes test too, I'm not quite sure why, but if they think I need it, then I'll just do what they recommend.

Table 6.10 Nicola being in the spotlight

Narratives drawn on in this monologue		
Participant	**Title**	**Theme**
Nicola	*Big girls don't have babies*	Seeing is believing
Stories drawn on in this monologue		
	Title	**Theme**
Nicola	*Big girls don't conceive*	Seeing is believing
	Seeing is believing	Seeing is believing

I don't mind them keeping an extra eye on me	Doing what they recommend/Reproductive citizenship
I've stopped going out	Anything can happen
Being a 'good mother'	Being in/visible/ Reproductive citizenship

Motif
Being in the spotlight

6.7.1 Commentary and discussion

As with the other participants, despite a positive pregnancy test and pregnancy symptoms, Nicola's stories suggested that began her engagement with the community midwife barely believing she was pregnant. Her narrative of her early pregnancy further highlighted that the feelings of tentativeness she experienced towards her pregnancy were temporal in nature and, in this respect, I found that the marking of time shaped the way all the women engaged with risk discourse, biomedical technologies and medical advice. This commentary explores experience of early engagement with MHC.

Doing what they recommend

Analysis of Nicola's stories about seeking early pregnancy care revealed that she anticipated having to defend her practices in relation to her diet and levels of physical activity. This finding mirrors those of Mills, Schmied and Dahlen (2013) who found that larger women struggled with how they imagined MHP framed them. Further analysis of Nicola's stories illuminated that Nicola realised that due to her embodiment she was easily identifiable as a "health offender" (Tischner & Malson, 2008: p.261), and she anticipated the midwife would assume she was "lazy or ate rubbish", as this quote from her interview demonstrates: "I asked her about healthy eating and diet, not because there's anything wrong with what I eat, but because I'm bigger and I thought I should". Nicola told me that she wasn't "bothered about what people think", however, it was also clear from what she said that these concerns were at the forefront of her mind in the context of the consultation and she was keen to position herself as a 'responsible mother'.

Analysis of Nicola's stories also revealed feelings of disempowerment in that she made her position clear saying it is "something I have to accept". Further analysis of Nicola's interview narrative suggested that her experiences of prenatal and early pregnant embodiment were highly important: setting the context for her initial engagement with the community midwife. Her stories about early pregnancy also illuminated an important aspect of the women's experiences of MHC, demonstrating that during interactions with MHP they were often rendered in/visible (Tischner & Malson, 2008).

Like the other women in the current study, Nicola's stories suggest she was unaware her pregnancy would be categorised as 'high-risk', however, she was painfully aware of the possibility that she would face criticism in relation to her larger size. This is a finding noted in similar studies (e.g. Furber & McGowan, 2011; Heslehurst *et al.*, 2015). Further, it is important to note that, although Nicola was keen to have her pregnancy confirmed by an expert, she had also emotionally prepared herself for this interaction. In the interview she used the metaphor: "being in the spotlight" to demonstrate her awareness of her highly visible and stigmatised larger body (Warin & Gunson, 2013) which my analysis suggests rendered her vulnerable to reductionist unsolicited advice about nutrition and physical activity.

The position Nicola took in her story about her appointment with the midwife was typical of the stories told by the other women, all of whom had reluctantly resigned themselves to having to listen to sometimes protracted explanations of basic information about nutrition. It is from this position that Nicola and the other women began their engagement with MHC: already feeling their pregnancies were precarious, seeking the reassurance of biotechnologies, but also feeling trepidation about engaging with MHP.

I was particularly struck by Nicola's comment about feeling relieved when the sonographers were "nice to her". I felt that it suggested she expected otherwise I wondered about her previous experiences of healthcare, but at the time I didn't ask her. What Nicola said however, echoes that of Heslehurst *et al.* (2015) who suggested that previous negative healthcare experience may take on a special significance during a 'high-risk pregnancy', due to larger women's feelings about

potential pregnancy complications related to body size. I suggest that as Nicola found ultrasound scans so reassuring she was happy to comply with the recommendation for additional scans to monitor the growth of the baby (Harris *et al.*, 2004). As this chapter develops however, we will see how ultrasound technology shaped the women's experience of their pregnancies in ways which were far from reassuring.

As I will go on to discuss throughout the finding chapters, the notion of the highly stigmatised and visible large body and the silenced invisible individual (Martin, 1989; Tischner & Malson, 2008) captures closely how the women in the current study positioned themselves in stories describing interactions with MHP. This is an important aspect of the study findings which I suggest may be imagined in terms of the 'obese' body encapsulating the invisible and silenced individual i.e. (in)visible. In the next monologue I present Vron's early pregnancy experience which illustrates how the participants positioned their responsibilities in relation to the wellbeing of the foetus. Vron's experience of her pregnancy demonstrates that, like Nicola, she is rendered (in)visible. These findings extend those of Heslehurst *et al.* (2015) who suggest that the high-risk status of larger women's pregnancies may provoke feelings of responsibility and guilt, demonstrating that women may feel diminished as individuals.

6.8 Monologue 7 - Vron: a 'good mother'?

On a Friday in December the doctor phoned me and said the reason I haven't been having periods is not because of any problem with my hormones, it's because I'm pregnant. My immediate reaction was to cast my mind back to what I'd been doing in the last couple of months. I remembered all the weddings and hen nights[53] I'd been to, and how much alcohol I'd drank. I was horrified. I imagined that anything could have happened to the baby. I was in shock and needed time to think about what to do. On Monday I phoned the doctor and said I would definitely be keeping the baby and he said: "book yourself into see the midwife as soon as you can, take folic acid and don't touch cat litter or eat any pate or cheeses".

[53] A 'hen night' is a UK term for a party for the female friends of a bride prior to her wedding.

I couldn't get an appointment with the midwife for a month which was hard as I was really worried I'd harmed the baby. I was 13 weeks and 4 days pregnant by the time I had my scan, and at that point I was already quite stressed about my weight, thinking: "what am I doing, how is this affecting the baby?" To make things worse, my mum, and my partner Jack were wrapping me up in cotton wool, and to be honest the strain of keeping my pregnancy a secret was beginning to tell on me; I was so worried and I felt like I had nowhere to turn. As it was going to be a whole month until I saw the midwife I went out and bought a book which told me what not to eat. I suppose I feel that eating the right things is one of the things I can actually control. I know that I'm going to put on weight and that's going to put even more of a strain on the baby but unfortunately you can't go back in time.

Table 6.11 Vron: being a 'good mother'?

Narratives drawn on in this monologue		
Participant	**Title**	**Theme**
Vron	*Working hard and taking responsibility*	Reproductive citizenship
	You can't take the risk	Reproductive citizenship
	They'll tell you anything that you need to know	Doing what they recommend
	I'm responsible for the baby: it's inside me	Reproductive citizenship/Womb and foetal permeability
Stories drawn on in this monologue		
	Title	**Theme**
Vron	*You're pregnant!*	Womb and foetal permeability
	I assumed it was me	Seeing is believing
	The longest month	Anything can happen
	Reaching the limit	Anything can happen
	I bought a book	Anything can happen/Reproductive citizenship
	I don't want to risk anything	Womb and foetal permeability/ Anything can happen/Reproductive citizenship
Motif		
Being a 'good mother'		

6.8.1 Commentary and discussion

The 'good mother' and the vulnerable foetal body

I found Vron's account of her early pregnancy experience emotionally difficult to listen to due to her discussing the possibility of terminating her pregnancy. This was not due to my own status in relation to fertility, or my views on abortion (I fully support all women's right to make decisions about their bodies), but that I felt concerned about the nature of the information on which she would base her decision.

When I interviewed Vron at the beginning of her pregnancy I was struck by her embodiment of personal responsibility for the foetus. Her stories of early pregnancy were characterised by worry about the wellbeing of the developing foetus due to what she felt were less than ideal circumstances at the time of conception. McPhail *et al.* (2016) have already drawn attention to how MHP position larger pregnant women as "constantly at risk and as risks to their fetuses [sic]" (p.99). Vron's interviews were scattered with stories with a focus on foetal development. Over the course of her interviews I became aware that the shaky beginnings of her pregnancy appeared to have a far-reaching impact on how she felt as a pregnant woman. My analysis of these stories revealed how seriously she took these risks, and how she positioned her body and her consumption as posing a risk to foetal development. Further, my analysis revealed that this positioning entailed a high degree of emotion work due to the level of personal responsibility Vron assumed.

I noted that Vron's focus on what she ate seemed to suggest that she believed that, just as the consumption of alcohol may directly negatively influence the health of the foetus, eating the 'right things' may have the opposite effect, making good her previous 'failings'. I suggest that Vron's experience illustrated her expectations in relation to how her actions are inexplicably linked to the wellbeing of the foetus. Lupton (2012a, 2012b) argues that the rendering of the foetal body as highly permeable has the effect of emphasising its fragility and vulnerability. Likewise, Warin *et al.* (2012) describe the current preoccupation with the permeability of the foetal and pregnant body in terms of 'modes of seepage'. Vron's experience perhaps adds another dimension to this 'seepage' in that she expressed concerns about how the size of her body places a "strain on the baby". In a later monologue in the next

chapter I present findings about how notions of maternal responsibility and blame shape Vron's experiences of the second and third trimester of pregnancy when she is accused of causing her baby's growth spurt. Ultimately, as we will see, the MHP focus on maternal consumption, as related to the size of her foetus, becomes a contentious issue; exposing contradictions in the medical management of her pregnancy to the point where she loses trust in MHP 'expert' opinion.

6.9 Conclusion

I suggest that the findings I have presented in this chapter explicitly demonstrate the disjuncture between the women's experiences and MHP framings of larger women. The chapter also reveals the complexity of the interactions and practices larger women experience, demonstrating how early tentative pregnancy experience begins to be shaped by engagement with the practices and interactions which form MHC.

Importantly, the chapter also demonstrates how notions of targeting and balance appeared in MHP narratives in relation to anticipated complications associated with larger embodiment. And how medical technologies and equipment play a significant role in practices involving the targeting of larger women in the context of MHC. In this respect I found that MHP drew on anti-obesity discourses of risk, blame and responsibility when they believed women were failing to act responsibility, and conversely, they criticised the 'label of maternal obesity' when they believed women were being unnecessarily targeted (i.e. when they are 'fat, fit and healthy'). This is an important aspect of the findings demonstrating some of the tensions and complexities larger pregnant women encounter in MHC spaces at all stages of their pregnancies as I will demonstrate in the next two chapters.

The findings reveal that larger women's early pregnancy experiences are far from straightforward and involve high levels of emotion work in relation to fertility, pregnancy loss, and 'what a pregnant body can do'. In some respects these uncertainties mirror those which have been discussed elsewhere (e.g. Ross, 2015b); however, I found that the women in the current study also had a deep distrust of their body's capabilities based on their prenatal embodiment. The findings also bring sharply into focus the level of responsibility the women felt in relation to protecting

the foetus. I found that the women's concerns began as soon as the pregnancy was confirmed and tended to increase once they began contact with MHC. This situation appeared to make the women more dependent on medical technologies and medical expert knowledge over their own embodied knowledge. These findings are important as they demonstrate that larger women may feel less secure about their body's ability to maintain a pregnancy, making them more vulnerable to increased levels of medical intervention.

The findings suggest that the highly visible nature of larger women's embodiment rendered them as targets for additional medical screening (McCullough, 2013); however, I found that targeted screening also tended to increase women's feelings of guilt and responsibility. Furthermore, my findings suggest larger embodiment tends to render women in/visible (Tischner & Malson, 2008) as is demonstrated by the levels of unsolicited advice and the assumptions made about their lifestyles in the context of midwifery consultations. This aspect of the findings is discussed within social science literature (e.g. Tischner & Malson, 2008; McCullough, 2013); however, my analysis extends previous writing - demonstrating that, although larger women resent unsolicited advice relating to nutrition, in contrast they welcome additional screening due to fears that their embodiment places additional 'strain' on the developing foetus. As I will demonstrate in the next chapter the embodiment of the 'responsible mother' may create a unique difficulty for larger women in the context of a focus on consumption and additional foetal growth monitoring, especially in a context where women are rendered invisible as individuals.

These findings demonstrate that women's early engagement with MHC is likely to have great significance for larger women who may require additional emotional support and reassurance about their pregnancies. However, as larger women may also fear being criticised in relation to their increased adiposity, this is an aspect of early pregnancy which women may find emotionally challenging. Larger women's early pregnancy experiences have been underexplored and these findings are therefore important as they illuminate the significance of larger women's early contact with MHC. As the women's journey through MHC continues, I will

demonstrate further the significance of these findings in relation to pregnant embodiment in later pregnancy.

Chapter 7 Mid and late pregnancy

In this chapter I present findings which illuminate how interaction with the wider maternity team shaped the women's experience of mid and late pregnancy.

7.1.1 Construction of monologues about mid and late pregnancy

When analysing participants' stories about mid and late pregnancy I was surprised at the intensity of the focus on the growth of the foetal body and how the maternal body was positioned by the MHP as a barrier to accessing the foetus. The women told stories about repeat foetal growth scanning, foetuses with large abdomens, repeated tests for GDM and frustration with the focus on their consumption of food. Meanwhile, the MHP stories foregrounded the difficulties they had in assessing foetal growth and the challenges they faced in talking to women about weight related issues (see also Appendix 15 for sample analysis). These stories communicated a sense that both the MHP and women felt trapped by the situation. The MHP position suggested that they felt they had little option other than to provide care for larger women. On the other hand, the women felt concerned that although 'maternal obesity' was discussed as risky they were given vague information about weight-gain and were also advised not to lose any weight. I also felt trapped. I was hearing both sides of the same story and I felt strongly that all the participants' experiences were important. This was one of the points when developing my method of narrative analysis that I regretted my decision to explore both women's and MHP experience. It was also at this point I decided to present the findings as an intertwining story which moved back and forth between both sides. The following monologues aim to represent the prominent themes produced by the analysis of data from mid and late pregnancy.

The obstetric antenatal clinic

7.2 Monologue 8 - Jodie, midwife: do you know why you're here? Part 1

When women with raised BMI come to the antenatal clinic where I'm a midwife usually they're aware of the reasons for the referral. This is not always the case though, and so it can be *really* awkward when women arrive wondering why they're here. When this happens I use the referral form to show them that the community midwife has ticked the box that says: "BMI over 35". I've got to be really careful though because some of these women don't see themselves as obese, just tall and muscular. The important thing with maternal obesity is where a woman's fat is. If they've not much fat around their abdomen, which is what some of the obstetricians call central obesity, then I know we're probably not going to have problems monitoring the growth of the baby. This is one of the things which most concerns us. You see, bigger women tend to have either really small or really large babies so if we can't monitor the baby's growth then that's really difficult. So what I say to the women at clinic, and how much detail I go into, really depends on how they look. So you really need to see a woman before you talk to her about risks in pregnancy.

When women come to the clinic some of the obstetricians take a more direct approach, and they just say to women: "do you know why you're here?" I think this is a bit confrontational, and it's hardly surprising some women get upset! Some women are well aware that they're overweight, so they really don't need to have attention drawn to their weight in pregnancy. I think these are women who, like me, have probably struggled with their weight, and the last thing that I want is for them to feel targeted in pregnancy. It's difficult isn't it? Here we are trying not to draw too much attention to the woman's weight and make her feel bad, but at the same time we're telling her she needs extra monitoring for weight-related complications, they must feel blamed. When women are upset about the referral I've found the best approach to take is to try and divert attention away from their weight and say that we just want to check them for gestational diabetes and monitor the baby's growth with some extra scans. Women usually welcome extra scans and so they're quite happy with that.

Table 7.1 Jodie, midwife: do you know why you're here? Part 1

Narratives drawn on in this monologue		
Participant	Title	Theme
Jodie (midwife)	*They don't know why they're here!*	Fat, fit, and healthy
Jodie (midwife)	*I don't want women to blame themselves*	The label of maternal obesity
Lucy (obstetrician)	*Accessing the baby*	Body as barrier to the foetus
Amy (charge midwife, labour ward)	*Fat, fit and healthy*	Fat, fit, and healthy
Stories drawn on in this monologue		
Participant	Title	Theme
Jodie (midwife)	*They don't know why they're here!*	The label of maternal obesity
Jodie (midwife)	*I don't want women to feel targeted*	Fat, fit, and healthy
Emily (consultant obstetrician)	*Do you know why you're here?*	Fatness as socially contagious
Sarah (consultant obstetrician)	*Stop going on about it!*	Taking responsibility
Eileen (obstetrician)	*Finding the baby*	Body as barrier to the foetus
Eileen (obstetrician)	*You couldn't put any money on it.*	Body as barrier to the foetus
Sadie (midwife)	*Speaking the unspeakable*	Fat, fit, and healthy

7.2.1 Commentary and discussion

Raising the topic of weight

When analysing stories about communication I observed that MHP stories invariably included various medical technologies. In this respect, BMI charts, referral forms and ultrasound images all appeared to play a part in communicating information to women. Reflecting on this I was reminded of the times when I had pushed a BMI chart towards the unsuspecting mother of a child whose body was deemed 'overweight' or 'obese'. The chart serving as 'evidence' that something needed to be acted upon. I constructed this monologue, which draws on the narrative of 'fat, fit, and healthy', to present my findings about how midwifery framings of larger women influenced the nature of the conversations midwives had with women at the antenatal clinic. The monologue, builds on the findings discussed in 'Monologue 2: the new guidelines target women' and demonstrates how technologies support awkward

conversations, especially when women who don't identify as 'maternally obese', are confused about why they've been referred to the clinic.

Although little is known about MHP embodiment in the context of caring for larger women in pregnancy, existing literature demonstrates that midwives, irrespective of their own BMI, may be reluctant to raise the topic of 'obesity' due to concerns about offending women (Knight-Agarwal *et al.*, 2014; Adolfsson, Andresen & Edgren, 2013; Heslehurst *et al.*, 2013; Lee, Haynes & Gdarrod, 2012; Smith, Cooke & Lavender, 2012; Heslehurst *et al.*, 2011; Schmied *et al.*, 2011). However, larger midwives often feel they are poor role models (Schmied *et al.*, 2011), and slimmer midwives may feel awkward about their own embodiment (Foster & Hirst, 2014).

Previous research suggests that midwives may avoid raising the topic of 'obesity' due to fears about harming the relationship with women (Knight-Agarwal *et al.*, 2014; Heslehurst *et al.*, 2007; Smith, Cooke & Lavender, 2012). My analysis of the midwifery stories suggested that when they wanted to discuss adiposity they used the 'maternal obesity' guideline to assist in raising the topic of weight. While this may have made it easier for them to justify discussing adiposity with women, in practice my analysis suggested that they tended to frame these discussions as a highly complex and somewhat risky undertaking.

By paying close attention to how midwives positioned women in their stories I was able to gain a clearer picture of this complex situation. Studies tend to report little variation in the ways that MHP view higher BMI women (e.g. Heslehurst *et al.*, 2007). However, I found that larger women were not represented as a homogenous group and were typically framed in three main ways. Firstly; were the women who are viewed as fit, broad, and muscular (i.e. 'fat, fit and healthy'); these women's bodies tended to be viewed as less risky than women with fat on their abdomens, and therefore were viewed as less deserving targets of maternal obesity policies. In these cases midwives tended to play down women's status as 'obese' in favour of providing balance (e.g. by distracting women with the promise of additional ultrasound scans). Secondly, are women who were believed to be ignorant of their status as 'obese' (i.e. failing to notice their obesity: 'fatness as socially contagious'), these women represent the most difficult group, as raising the topic of 'obesity'

involved pointing out the 'abnormality' of their embodiment taking risks with regard to offending women. Thirdly, are the women who were believed to be aware of their status but are framed as women with 'issues', these women were positioned as somewhat fragile, using eating to deal with difficult emotions (Murray, 2008). Again, these women represented as a more challenging group of women due to the risks of upsetting them.

Do you know why you're here?

Previous research has highlighted that obstetricians may take a direct approach in raising the topic of 'maternal obesity' with women, an approach which some midwives find problematic (e.g. Knight-Agarwal *et al.*, 2014). In this respect, I found that the commonly used question: do you know why you're here? appeared across the obstetric and anaesthetists' data and was used in conjunction with various healthcare forms and charts to begin a consultation in clinic settings. The referral form seemed to help the clinic staff legitimise the need for clinic attendance. Furthermore, with the reason for the referral potentially embarrassing for all parties, the form also seemed to help to shift the blame for the referral back onto the referrer: reducing any awkwardness for the clinic staff.

I suggest that, on one hand the question, may serve the purpose of ascertaining women's understanding of the reason for the referral. However, the analysis of stories about talking to women in the clinic revealed that the question may also serve an institutional disciplinary function, in that was framed in such a way to require a confession from the responder - i.e., "yes, I'm overweight" (Foucault, 1978). A quote from Sarah (consultant obstetrician) illustrates this point:

> There are a lot of women who are healthy, so I often say to them: "do you know why you're here, why you've been referred to clinic?" And a lot of them will say: "because of my weight." And that's how I start a conversation.

I felt uncomfortable about the way that women were positioned in stories about referral to the clinic. These stories suggested that not only were 'healthy' women (to quote from Sarah) being referred to the clinic, but the positioning of women in stories about referral appeared reminiscent of a patriarchal MHC system (Bordo,

2003; Oakley, 1993; Rúdólfsdóttir, 2000). In Part 2 of this monologue draws on stories within the theme 'ignorant women' which illustrate how larger women tend to be framed through a deficit model (Knight-Agarwal *et al.*, 2014; Furness *et al.*, 2011) as lacking in basic knowledge about nutrition, therefore, requiring the expertise of the midwife in order to eat properly in pregnancy.

7.3 Monologue 9 - Jodie, midwife: do you know why you're here? Part 2

I think I've got a pretty good knowledge about nutrition so I'm always looking for an opportunity to talk to higher BMI women about their eating habits when they come to the clinic. Sometimes it's a bit awkward though and I think some of them look at me and think: "you're one to talk!" I had an 18-year-old in last week with a BMI of 45 and GDM. She admitted to drinking 35 cans of coke a day! We couldn't believe it, and the obstetrician was shaking his head in despair and saying: "have these women got no common sense?" This woman didn't eat any vegetables or fruit at all and couldn't cook, so I don't know how she was going to be able to look after a baby. I think some of these women just feed their kids on McDonald's all the time so it's no wonder we're seeing a rise in the numbers of people with type 2 diabetes.

Table 7.2 Jodie, midwife: do you know why you're here? Part 2

Narratives drawn on in this monologue		
Participant	Title	Theme
Jodie	*We have some quite unhealthy ladies*	Educating women about eating/ talking about weight
Stories drawn on in this monologue		
Participant	Title	Theme
Jodie	*Future generations*	Fatness as socially contagious
Kenneth (consultant obstetrician)	*It's not about weight: it's about common sense*	Ignorant women

7.3.1 Commentary and discussion

As with the community midwives, my analysis of the interview with Jodie who worked in the antenatal clinic revealed that she tended to draw on the narrative 'fatness as socially contagious', as her primary means of understanding larger

women. This positioning seemed to drive her desire to educate them. Her story entitled 'Future generations' illustrated that her focus on providing information seemed to close down opportunities for conversations about anything other than 'healthy eating' and exercise. My analysis also suggested that although Jodie sought to protect women's feelings by distracting them from feeling targeted with the promise of additional scans, despite this she also seemed to place a high degree of significance on discussing nutrition with women, therefore, targeting larger women as in need of her advice.

The woman who drank 35 cans of coke

When analysing stories set in the hospital antenatal clinic I was intrigued about the story about the woman who drank 35 cans of coke. Not only did it seem far-fetched (to me) but it reoccurred in other MHP stories, for example, Kenneth, Jodie, and Lesley also told a story about a woman who drank 35 cans of coke (a similar story about a woman eating 20 packets of crisps also appeared in a story told by Amy). Although the number of cans of coke in these stories varied slightly, the story was a recurring motif. Reflecting on this story, which appeared to be about overconsumption and lack of nutritional knowledge, I realised that perhaps it was used to communicate a specific message about how MHP felt about trying to educate women in the clinic. Therefore, I think the story was used to illustrate how seriously the midwife viewed the problem of 'maternal obesity' in terms of women's practices.

Although this story appears to represent what might be thought of as the 'extreme end of the problem', I noted that Jodie's interview narrative framed all high BMI women as deficient in their knowledge about nutrition. As with the community midwives, Jodie therefore seemed to take a reductionist approach to framing her understanding of larger women. Her stories also suggested that she was conscious of her own larger body and the contradictions it seemed to represent as a poor role model. However, despite this, my analysis revealed that she drew unquestioningly on mainstream obesity discourse, a finding mirrored in other research (Carryer, 2001), making assumptions that the women at the clinic require her support with nutrition.

Previous research has suggested that midwives often feel at a loss to identify their role with larger women, and therefore tend to focus on enquiring into women's

eating habits, providing women with nutritional advice (often feeling unqualified to do so) (Heslehurst *et al.*, 2011; Heslehurst *et al.*, 2013). I also noted that MHP tended to assume that the transfer of knowledge would solve women's 'weight-problems': enabling them to reduce their weight to within acceptable medical limits.

The notion of providing information is further discussed when the women's journey through MHC reaches the obstetrician at the obstetric antenatal clinic, demonstrating how information relating to the risks of 'maternal obesity' is a somewhat poisoned chalice. In the next monologue we see how Anna experiences the focus on weight and nutritional information during her pregnancy.

7.4 Monologue 10 - Anna: feeding the foetus

Once I got past all the early worries, new ones came along. I saw the midwife at the antenatal clinic and she weighed me. "You've gained 2 and a half kilos, but we don't expect you to put on anything until 6 months", she said. She was upset, so that sort of upset me. I think I'm doing all the right things, I stopped smoking the minute I found out I was pregnant, so I don't know how I'm supposed to not gain *anything*!

Although I had loads of questions for her about pregnancy sickness and food cravings, we had the usual conversation: she lectured me like a baby and told me all about counting calories: "it depends how much you move about", and all that: nothing I don't already know. In fact, the whole conversation made me think that she wants me to live on grass and water. I wondered if she'd ever been pregnant, ever had food cravings, ever felt like your body's been taken over by aliens? She told me to go swimming, which I'm definitely not going to do, I don't fancy getting a urinary infection from the public baths. That was it really; bit of a one-way conversation. She gave me a leaflet, and I thought: "shame it's not like that in real life!"

I did a lot of research after that, and found out that if you gain too little weight it can harm the baby, it can even cause disabilities. I also found out that I can't go on a diet: it's too late for that. So I need to deal with whatever, and do whatever I can. I think I'm only allowed to gain 9 kilos, which is a lot less than slimmer girls, so I signed up for this *Change your life in 30 days* Facebook page. It's like having your own personal trainer; you do all these exercises right in your living room and learn how to

eat smarter. It's all about choice you see. I had some kind of Chinese couscous chicken yesterday, I thought it was a bit too spicy, but I thought maybe I should get the baby used to having spicy food, you know, save me training her later.

I'm having extra scans to monitor her size because she's bigger than average, apparently she has long legs! I found out from one of my friends that everyone's stopping taking pregnancy vitamins because they make the baby put on weight. Anyway, I'm not keen on the idea of a C-section so I stopped taking mine too. I've been tested for the kind of diabetes you get in pregnancy but it was negative. I was a bit surprised, especially with all the talk about big women getting it. I'm getting a lot bigger now though and people are asking me if I'm having triplets. I just laugh it off but actually it's a strain being this weight. The doctors don't really say much, they just write 'higher BMI' on your notes.

Table 7.3 Anna: feeding the foetus

Narratives drawn on in this monologue		
Participant	Title	Theme
Anna	*Reproductive citizenship*	Reproductive citizenship
	Gaining control	The struggle for control
Stories drawn on in this monologue		
Participant	Title	Theme
Anna	*I'm not supposed to gain any weight for 6 months!*	Being visible/invisible/Reproductive citizenship
	Change your life in 30 days	The struggle for control/Reproductive citizenship
	She treats me like a baby	Being visible/invisible
	I've got the bowl of fruits	Being visible/invisible/Reproductive citizenship
	Stop feeding the foetus	Womb and foetal permeability
	I expected to have gestational diabetes	Being visible/invisible
	All you need is to pick up fruit	Reproductive citizenship
	I need to teach my baby how to eat	Womb and foetal permeability
Motif		
Feeding the foetus		

7.4.1 Commentary and discussion

As I discussed in Chapter 2, in the context of larger women's pregnancies, gestational weight-gain (GWG) tends to be a somewhat thorny issue (e.g. Nyman *et al.*, 2010; Furber & McGowan, 2011; Furness *et al.*, 2011; Schmied *et al.*, 2011; Smith & Lavender, 2011; Heslehurst *et al.*, 2015; DeJoy, Bittner & Mandel, 2016). Although these studies suggest that the topic of weight is a contentious issue, none have thus far drawn attention to how biomedical risk discourse conflating maternal size with foetal size, combined with foetal growth monitoring, and OGTT act on women during pregnancy. In this chapter the monologues I present vividly depict how these factors shape larger women's experience of the second and third trimester of their pregnancies.

With previous research suggesting that weight is the focus of larger women's MHC, I was not surprised therefore that the participants told many stories about the discussions they had with MHP about weight-issues. I noted that concerns about GWG were especially acute in the context of discussions about the potential of women having either a very small, or very large baby. In this respect, the women's stories suggested that, although weight was the focus of much of their antenatal care consultations, the advice given to them tended to be non-specific. My analysis suggested that this situation left the women feeling concerned about weight-management in pregnancy. For example, Angie, like Anna, questioned why her weight was not monitored more closely during her pregnancy. Vron deliberately asked to be weighed at her clinic appointments. She did this partly so she could defend herself from accusations that she was a 'bad mother' by demonstrating firstly, that she was concerned about this aspect of her pregnancy, secondly that her GWG was reasonable, and thirdly, as it gave the midwife the opportunity to comment on her weight and/or weight-gain (she never did). Meanwhile Kacey was worried about weight-loss due to morning sickness that lasted all day. It was only Susie, who was following a Slimming World® diet plan, which is endorsed by the RCM[54], who at the beginning of her pregnancy at least was reassured by the midwife, and therefore felt less concerned about weight-gain. In many ways Susie's approach to pregnancy

[54] See https://www.rcm.org.uk/slimming-world for the Slimming World® and RCM joint website

modelled the 'good mother', shaping her interactions with MHP and I will discuss this aspect of the analysis further in Chapter 7.

Being visible

In Section 2.8.4 I presented findings which suggest that MHP felt that larger women were not only unwilling to discuss weight-related issues but they also failed to follow advice. However, Anna's stories about her antenatal consultations explicated how she felt the midwife targeted her with the 'usual conversation', positioning her as responsible for any subsequent weight-gain. My analysis of Anna's stories, which contained vivid descriptions of this dialogue, demonstrated the deep resentment she felt about being positioned as a woman who lacked knowledge about nutrition.

I suggest that Anna's experiences are likely to be a product of the current NICE guideline, *Weight Management Before, During and After Pregnancy, PH27* (NICE, 2010) which advises MHP to "discuss her eating habits and how physically active she is" (p.11). As I discussed in Chapter 6, community midwives may enact this guideline by drawing on written information to support them in providing women with information i.e. 'the special pink leaflet' (see Section 6.4). Anna, however, drew attention to the fact that, rather than having a discussion where she was able to raise the issue of food cravings and nausea, she was, "lectured like a baby" and left feeling infantilised (Rúdólfsdóttir, 2000). This finding mirrors that of Mills, Schmied and Dahlen (2013) who noted that larger women complain about MHP being "preachy" (p.315). Furthermore, it is clear that this conversation placed Anna in 'moral jeopardy' (Murphy, 1999) in that she was positioned in this dialogue as a 'bad mother' who lacks basic nutritional knowledge (Markens, Browner & Press, 1997; Warin *et al.*, 2012; Jarvie, 2016).

Being invisible

As I have discussed, Anna's stories about her engagement with MHC were dominated by concerns about the management of her weight and the food she consumed. In this respect, I suggest that Anna as a person is rendered somewhat invisible in that she is not given the opportunity to talk about her embodiment. This finding concurs with previous research which suggests that the focus on (over) weight and weight related complications detracts from the experience of pregnancy

(e.g. Nyman *et al.*, 2010; Mills, Schmied & Dahlen, 2013; DeJoy, Bittner & Mandel, 2016). The discussion Anna has with the midwife also rendered her as somewhat invisible in that the midwife made assumptions about Anna's knowledge and lifestyle (Tischner & Malson, 2008; McCullough, 2013; Hansen, 2014). For example, had the midwife discussed the types of activities Anna liked to do she would have discovered how permeable Anna believed her body to be as is demonstrated by her worries about infection from public baths.

The stories Anna told about her consultations with the midwife suggested that she felt somewhat alienated and her questions about food cravings and nausea went unanswered. Furthermore, Anna was advised not to lose or gain any weight during the first 6 months of her pregnancy. This was a prospect she felt was unrealistic in the context of nausea, vomiting, food cravings and the natural weight-gain associated with a growing foetus, placenta and amniotic fluid. Analysis of these stories suggested that the advice she was given appeared to make little sense in the context of her embodied experience in relation to eating and appetite. Furthermore, Anna's talk about joining the *Change your life in 30 days* Facebook page may appear quite positive as it suggests she was keeping fit by exercising in her living room. However, she did so in response to her concerns about the growth of the foetus and notions of individual responsibility. Rather than viewing Anna's actions as positive I argue that her actions were a response to her concerns about GWG and foetal growth. What is obscured is the level of emotion work she engages in during the second and third trimesters of her pregnancy.

Putting the foetus on a diet?

Anna's story about stopping taking her pregnancy vitamins due to fears about foetal growth and her talk about training the foetus to eat spicy food (which may have been somewhat tongue in cheek) illustrate how she viewed the permeability of the foetus in relation to her own consumption (Warin *et al.*, 2012). This positioning of the foetus has relevance for Anna's understanding of her responsibility towards the foetus and foetal growth.

In a later monologue I revisit this theme exploring Vron's experience of foetal growth monitoring and I will present findings which demonstrate how her experience

of foetal growth monitoring and dietary surveillance during the later stages of her pregnancy implicate her as responsible for the growth of her foetus (see Section 7.7). The next 2 monologues contrast larger women's experience of MHC setting out the obstetric framing of the larger body setting the context for the interactions larger women have at the antenatal clinic.

7.5 Monologue 11 - The obstetricians: getting the message across

When I first started as an obstetrician in 1996, obesity was something that maybe one or two patients had, but it's really become a major issue now. I mean a BMI of 35 is almost considered *normal* amongst the obstetric population. I don't think it is normal, but it is so frequent, and so common, I don't even look twice anymore. In the past big BMIs of 45 caused a good deal of discussion, but now we see people with BMIs of 50, 51, 52, and we've even had to provide wider beds, trolleys and equipment to move women after surgery.

One of the things worrying me about the obstetric population getting bigger is that people look around and think they're normal. And I think it's likely that their children will also think that it's normal. When it's not. And of course, we do everything that we can to try and manage these ladies in pregnancy. So I think they get a false sense of security because we cope with most things. We have to. I think my biggest fear is that, if we just accept maternal obesity as normal, we'll never get them back.

Obviously, by the time we see obese women in clinic it's too late to change their situation. But I feel that if I get the message across to them, that it's not good to be obese when you're pregnant, then there's a chance that their friends, relatives and children will also eventually one day appreciate it as well. So, when I see them at the clinic I usually start by saying: "do you know why your midwife's referred you into the clinic?" And often I'm shocked that most of them don't know why they're here, and half of the women don't even know what a BMI is, never mind understand the risks to themselves and the baby.

What I find when I talk to women about obesity is that I get a very mixed response. One or two ladies will be very upfront and say: “oh, I know I'm overweight and I should have done something”. But *most* people almost deny there's any problem, and don't see why we're doing any of these tests. I think it’s because they don't see themselves as being any different to anybody else. This is one of the reasons why I like to give obese women the *full* picture of risks when I see them in clinic. So I tell them that maternal obesity increases the risk they will have an abnormally large baby, which of course can complicate things, as it increases the risks of a forceps delivery, and also the chances of a haemorrhage after delivery. Of course there’s also an increased risk of getting an infection in the wound if they have a caesarean section, and it’s more likely that obese women will need a section anyway. These are the most *common* things we see. But I also tell them about some of the less common things if I get the chance. Things like developing a blood clot in their vein after delivery, or being more likely to have a miscarriage at the beginning of pregnancy. These are not really what I'd consider to be the common issues, they’re just the ones that, if I get the opportunity to give them the *full* picture of risks, then I would include those.

So really it’s my role to explain to them why they’re high-risk and what we’re going to do about it. I usually focus quite a bit on delivery because there are quite a lot of things that can go wrong at delivery that might be due to obesity. One thing that I’m really aware of though, is that if something happens, say a woman has had a stillbirth, a postpartum haemorrhage, or a section for failure to progress, then I am really careful of not telling them that this might not have happened had they not been obese. So I’m aware that I try to protect women’s feelings once a complication has actually happened, so you know, I think it's easier to give them the information beforehand.

Table 7.4 The obstetricians: getting the message across

Narratives drawn on in his monologue		
Participant	Title	Theme
Emily (consultant obstetrician)	*We’ll never get them back*	Fatness as socially contagious
Lucy (obstetrician)	*Getting the message across*	Ignorant women

Kenneth (consultant obstetrician)	*Do you know why you're here?*	Taking responsibility

Stories drawn on in this monologue		
Participant	Title	Theme
Emily (consultant obstetrician)	*Do you know why you're here?*	Ignorant women
Emily (consultant obstetrician)	*It used to be unusual*	Fatness as socially contagious
Emily (consultant obstetrician)	*Being fat is not normal*	Taking responsibility
Eileen (obstetrician)	*Litigation's a problem*	Body as barrier to the foetus
Sarah (consultant obstetrician)	*You can't say that!*	Taking responsibility

7.5.1 Commentary and discussion

Fatness as socially contagious: fighting the epidemic and risk discourse

This monologue illuminates the 'worst-case scenario' (discussed in Section 6.5) from the obstetricians' viewpoint. I constructed the monologue to demonstrate the ways obstetric consultations, and practices, operated in obstetricians' stories as acts of resistance in the context of a gradual increase in the numbers of larger women who believe they are 'normal' size, but are in fact 'obese' (Fatness as socially contagious). In analysing these stories I noted that obstetric resistance to the 'obesity epidemic' operated in two ways: firstly, through a direct approach to talking about body adiposity (e.g. using the medical term 'obese' in obstetric conversations with larger women); and secondly, through the obstetric approach to explaining, in great detail, the risks involved with 'maternal obesity'. In this commentary I discuss the latter.

The quote from the obstetrician Emily: "we'll never get them back", comes from a prominent narrative running throughout her interview talk. When I analysed stories in which this narrative appeared, I was able to illuminate what the midwives viewed as the 'targeting' of larger women from an obstetric viewpoint. I noted that, unlike some of the midwives who sought to provide balance in the face of medicalisation, the obstetricians viewed themselves as the somewhat innocent victims of a 'maternal obesity crisis'. This finding is not unique, Schmied *et al.* (2011) described two themes in their research also capturing MHP views on 'maternal obesity': 'creeping normality' and the 'runaway train'.

In the current study, the notion of ‘never getting them back’, demonstrates the obstetric concern with stopping Schmied *et al.'s* (2011) ‘runaway train’: revealing the ways obstetricians described seeking to hold their position on ‘normal’ or ‘healthy childbearing bodies’. My analysis also revealed that, as far as the obstetricians were concerned, it was too late for the larger women who attended the antenatal clinic, however, future childbearing women could be ‘saved’ from becoming pregnant when ‘obese’. My analysis suggests they did so by drawing on the narrative ‘fatness as socially contagious’, providing women with detailed information about risk in order that yet to become pregnant women can recognise their ‘obesity’ and ‘choose’ to become slimmer prior to pregnancy.

When analysing stories about talking to women about the risks of ‘maternal obesity’ I was very struck by the directness of these consultations. I also found surprising, and a little upsetting, the prominence to two narratives which ran through Lucy’s interview text: ‘getting the message across’ and ‘people have to know risk’. Lucy’s interview was dominated by talk about providing larger women with detailed information about risk during consultations and what she hoped to achieve by doing so. I found it personally very difficult when Lucy described providing women with “the *full* picture of risks” (a direct quote) because she included the risk of early miscarriage for which there are few preventative treatments. I suggest, although Lucy may not be representative of the obstetric population, the provision of such a comprehensive list of potential complications (which she hopes the women will disseminate to the wider reproductive population) draw attention to the governance of larger women’s pregnancy, highlighting the disciplinary purposes of information about risk (Foucault, 1978).

Lucy’s story prompted me to examine in detail how women were alerted to risk in pregnancy and I found that risk discourse and neoliberal framings of body management (Rose, 1990; Lupton, 1995; Petersen, 1997) were drawn on in stories in which larger women are framed as abnormal, deviant, and somewhat ignorant of their situation. I noted that neoliberal framings of blame, responsibility, and risk operated implicitly in stories alerting women to their adiposity.

I certainly found that obstetricians couched the practice of providing women with detailed information about risk in terms of explaining the need for additional screening and monitoring. However, critics of this approach have suggested that MHP should more carefully consider how obstetric consultations impact on women's subjectivity (Edwards, 2005). However, obstetricians are advised to provide: "accurate and accessible information about the risks associated with obesity" (CMACE/RCOG, 2010: p.6). Existing critical literature discusses the practice of information-giving as a site where discourses of risk, blame and responsibility act on women (Coxon, Sandall & Fulop, 2014), providing a justification for increased medical intervention in pregnancy (Dahlen & Homer, 2013; Healy, Humphreys & Kennedy, 2016a), masking defensive practices in the face of concerns about litigation (Johanson, Newburn & Macfarlane, 2002). Some authors have also identified the emergence of the discourse of mother blame (Lupton, 2012a; Warin *et al.*, 2012; Warin *et al.*, 2011). These authors argue that the proliferation of mother blame discourse occurs in the context of the expectations placed on women to ensure their bodies are adequately prepared for pregnancy. This discourse serves to place undue pressure on women to make the 'right decisions' for the welfare of the foetus (e.g. Bell, Salmon & Mcnaughton, 2011; Lupton, 2011; McNaughton, 2011; Bell, Mcnaughton & Salmon, 2009).

This monologue has highlighted that the practice of information-giving may act as a means of alerting women to the 'abnormality' of their adiposity. The act of information-giving suggests that women are mere receivers of such information. However, as the obstetric narrative develops, we see in the next monologue how the framing of women and women's adiposity, reveals tensions in terms of who should take responsibility for the difficulties' obstetricians face in relation to 'maternal obesity'.

7.6 Monologue 12 - The obstetricians: taking responsibility

There's so much stigma around obesity, so it's no wonder people tend to tiptoe around the topic, avoiding challenging women about their weight in case they offend them. I don't feel like that though. So when I'm scanning I'll just say to them: "will

you please lift up the layer of fat?" or, "your tummy layer." And if they start complaining about the scan picture I say: "well that's all fat tissue that the scan waves have to go through". It's so much harder to get the scan images, but I don't think these women realise this.

Sometimes when I talk to women in the clinic about the risks of being overweight in pregnancy they can be quite defensive. So raising the subject of weight is quite difficult. I don't want to upset them, but at the same time it's important they understand how a high BMI changes their pregnancy. Often they don't like it though, like a woman with a BMI of 40 I saw at the clinic last week. She said she'd lost weight since becoming pregnant and was adamant that we re-calculate her BMI. The cut off for having to see the anaesthetist for an antenatal screening appointment is 40 so she was trying to get out of that. Anyway, when we re-calculated her BMI it was 39.9 and so she said: "I don't need any of that!" And refused all input, and was very, very defensive. She'd obviously no idea of how difficult it is to deal with emergency situations when women are obese. Anyway, what could I do? All you can say is: "fine! I can only tell you what I would recommend, if you choose not to do it then that's entirely up to you".

I think a lot of people today are not realising that to be fit and healthy requires effort. It requires responsibility on your own part, for looking after your own health, and it requires you to be proactive and to work hard. It's not something that most people find easy so I think people just want a magic cure that's going to make it all go away. They want liposuction or a tummy tuck, or something that is not going to address the issue that they're not making healthful choices. Like the woman I had in with abdominal pain last week. When I saw her she was eating a packet of crisps to wash down the two Domino's pizzas[55] she'd eaten earlier. And they wonder why they get abdominal pain! When I was pregnant I continued to go to the gym everyday even though I experienced quite severe pelvic pain. I'm not a naturally skinny person or anything like that. I'll never be skinny, but I eat well and I exercise, and I work at it.

[55] Domino's is a UK pizza delivery company.

So you can see our position? They've got the right to make their own choices even when we disagree with them. It *is* difficult though: well, they make *our* life difficult. Although, sometimes I do feel quite sorry for them, you know, what can they do about their situation once they're pregnant? But it does leave us in a situation that *we're* the ones that have to manage all the risks, and *we're* the ones who have to tell them about these risks because they've no idea. I think the only time that we can actually do something about preventing the problem is by educating obese women about risk, and by regulating who can access infertility treatment. In fact, in assisted conception, women have to be below a certain weight before they're allowed to get it, and that does motivate people to lose weight. So I think that if they *have* to do it, then they can: they just need to be given incentives. I've seen people sign up to Weight Watchers[56] and lose four stones, so it can be done, quite easily.

Table 7.5 The obstetricians: taking responsibility

Narratives drawn on in this monologue		
Participant	Title	Theme
Lucy (obstetrician)	*Getting the message across*	Taking responsibility
Eileen (obstetrician)	*You need to be proactive*	Taking responsibility
Stories drawn on in this monologue		
Participant	Title	Theme
Sarah (consultant obstetrician)	*I don't need any of that!*	Fatness as socially contagious
Sarah (consultant obstetrician)	*Stop going on about it!*	Taking responsibility
Eileen (obstetrician)	*Two Domino's pizzas and a packet of crisps*	Taking responsibility
Emily (consultant obstetrician)	*People just deny the issue*	Taking responsibility
Emily (consultant obstetrician)	*Weightwatchers is good*	Taking responsibility
Eileen (obstetrician)	*Litigation's a problem*	Body as barrier to the foetus

7.6.1 Commentary and discussion

Taking responsibility

Existing literature has identified that, when larger women enter pregnancy they tend to be constructed as posing a risk to the unborn child (McNaughton, 2011; Keenan &

[56] Weight Watchers is slimming club which operates in many Western countries.

Stapleton, 2010; Boero, 2007). In line with this literature I found that obstetricians tended to draw on a public health neoliberal framing of larger women, pointing out women's failings in terms of following current public health guidance (e.g. Lupton, 2013a; Saguy, 2013; Gard & Wright, 2005). In this respect I found that the obstetricians' and midwives' positionality within their stories contrasted their own self-disciplined weight-management practices with what they imagined larger women do or neglect to do, tending to frame larger women as unconstrained and morally reprehensible (Shildrick, 1997).

I suggest that this aspect of the analysis is particularly evidenced by stories such as the frequently referred to '35 cans of coke' (see Monologue 9), which was used to highlight the extreme end of how MHP understood larger women's failings in terms of consumption. The pizza story, like the coke story is a rare occurrence, but I suggest it was drawn on to make the point that larger women are failing to take responsibility for maintaining an 'acceptable size'. As discussed in earlier commentaries, this framing draws on a reductionist approach to understanding larger people, one which has been heavily criticised (e.g. Warin, 2015; Saguy & Gruys, 2010; Saguy & Almeling, 2008; Ross, 2005; Evans, Rich & Davies, 2004) for contributing to discrimination in MHC contexts (DeJoy & Bittner, 2015).

Perhaps as a means of countering potential accusations of discriminatory practice, it seemed that the obstetricians tended to frame themselves as innocent victims of the 'obesity crisis', demonstrating that they felt somewhat trapped in that they must bear the responsibility for managing any future complications and ensure safe delivery of the infant. This framing seems to suggest that obstetricians are also somewhat at the mercy of larger women in terms of gaining their co-operation for medical intervention.

The monologue further develops the communication issues which are discussed in previous monologues regarding raising the topic of 'obesity'. Furthermore, what is particularly illuminated is that, although MHP may somewhat fear being seen as contributing to stigmatised practices in relation to larger women (e.g. DeJoy & Bittner, 2015), some of their practices may have this effect. For example, I noted that some MHP practices appeared to be deliberately focussed on drawing attention to the

ways that larger bodies contribute to the difficulties MHP face in dealing with ‘maternal obesity’. In this respect, my findings suggest that MHP seek to Other larger women (Douglas, 1992) by communicating to women (via various practices) the difficulties larger bodies represent in pregnancy (i.e. asking women to take responsibility for the weight of their own fat). I suggest that these practices seem to manifest specifically as a means of combating the sense of powerlessness MHP may feel by transferring some power back to MHP through disciplinary practices designed to draw the women’s attention to their fat (Foucault, 1978, 1991).

Furthermore, my findings appear to suggest that disciplinary practices were most commonly seen in MHP stories and narratives where conflict draws on discourses of maternal responsibility and blame. These stories represent an important means with which to illuminate the positionality of MHP in relation to larger women. In particular these stories help to identify the ways MHC practices subtly, and sometimes overtly, are disciplinary in nature; providing a means for the obstetrician to draw attention to the ways that women’s bodies deviate from the norm. In this respect my findings mirror those of various scholars who also draw on Foucault's (1978) concepts of biopower and biopolitics to illuminate the ways ‘fat bodies’ are monitored and regulated (e.g. Lupton, 2013a; Harwood, 2009), helping to explore the ways that larger bodies are socially regulated through, “medicalization, governance, surveillance and discrimination” (Warin, 2015: p.7).

One of the ways that I suggest that institutional obstetric practices may provide a means to discipline larger women (Foucault, 1978) was through use of particular language which I identified within obstetric stories. For example: "will you please lift up the layer of fat?” or, "your tummy layer" (a quote from Emily’s story ‘People just deny the issue’). I suggest that by making the request in this way Emily instructs the woman to take *responsibility* for her own fat. I further suggest that the request also represents the Othering of larger women through practices that draw attention to ‘fatness’. Such practices can be interpreted as a fairly subtle form of disciplinary practice. However, I also found that more obvious forms of institutional power existed such as the practice of preventing larger women conceiving by restricting their access to fertility services. Some authors have argued that denying larger

women assisted conception is a form of eugenics (i.e. McPhail *et al.*, 2016). In Susie's stories in the next chapter we see how she initially complies and then resists this obstetric practice in the context of her pregnancy (see Section 8.7). The next monologue illuminates how the surveillance of foetal growth acts on Vron's experience of late pregnancy shaping her thinking about childbirth.

7.7 Monologue 13 - Vron: feeding the foetus

It wasn't until I had my 20-week scan that I stopped worrying so much about whether the baby was okay. I can't tell you how relieved I was to hear the sonographer say: "everything looks fine on scan". After the 20-week scan I was scheduled to have a growth scan a few weeks later. After the growth-scan the consultant sat me down and said: "right your baby's big, you'll have to watch what you're eating". It turns out that the baby's growth was on the mid-line at the 20-week scan, but now it was at the top. So he was like: "have you been eating properly? Have you been having sugar in your tea? Have you been drinking sugary juices?" And I'm just like: "well, you know, I've done my research and my diet's pretty good". Talk about being in the hot seat!

I've noticed people keep an eye on what I'm eating. I had some snacks at a party the other week and someone said: "is that you eating crisps[57]?" People also stare at you and make comments about the size of your bump, which I find really difficult, because that's where I carry my weight, so I'm really conscious of it.

They've said that because the baby's big they won't let me go to term. So the midwife said that she'd do a sweep at 39 weeks which she did. Not much seemed to happen though, and by the time I saw the consultant a few days later I was getting quite panicky about what was going to happen and whether the baby was okay. So when the consultant greeted me with: "what can I do for you today?" I told her I wanted to be induced. "It's not procedure" she says, and I was like: "you've told me all the way through my pregnancy that my baby's really big, you've told me that you won't let me go to term". She said: "it's not procedure", and anyway, because of my size, the scans are not accurate. I couldn't believe it; I had been worrying all along

[57] What are referred to as 'crisps' in the UK, are otherwise known as potato chips.

about my body, about how my body would affect him. I trusted the health professionals; I relied on them. And so, to be told that the scans weren't accurate, to be getting totally different information at this late stage, was she right? Were all the other doctors scaremongering? Has it been drummed into them: scare the bigger women? They were going to leave me for another 12 days which made no sense to me, I mean, I know he's not gaining a pound everyday, but even an ounce a day it going to make him even bigger.

Table 7.6 Vron: feeding the foetus

Narratives drawn on in this monologue		
	Title	Theme
Vron	*What I put in my body is my responsibility*	Reproductive citizenship/ Womb and foetal permeability
	Doing what they recommend	Doing what they recommend
	I'm responsible for the baby	Reproductive citizenship
Stories drawn on in this monologue		
	Title	Theme
Vron	*20-week scan*	Seeing is believing
	Big baby	Visibility/invisibility/Womb and foetus as permeable
	The spa party	Reproductive citizenship/ Womb and foetal permeability
	Can I weigh myself?	Reproductive citizenship/ Womb and foetal permeability
	What have you been eating?	Reproductive citizenship/ Womb and foetal permeability
	My mum had a horrific birth with me	Anything can happen
Motif		
Feeding the foetus		

7.7.1 Commentary and discussion

Being visible

Although none of the previous studies I reviewed in Chapter 2 report women being held accountable for the growth of the foetus, previous research has suggested that larger women may experience open criticism in relation to weight-gain and eating

habits (Furber & McGowan, 2011). To this effect, Tischner and Malson (2008) describe embodied largeness as rendering the large body highly visible through the politics of visibility.

In the current study, I suggest that Vron's stories, which resonate with those of the other women, demonstrate that she is highly aware of the medical and societal supervision her larger body attracts (Bordo 2003; Longhurst, 2005b; Lupton, 2011). The monologue builds on Vron's early experience of pregnancy which I discussed in Section 6.8, and again clearly demonstrates the burden of responsibility she feels in relation to the development of the foetus. However, in the second and third trimester of pregnancy, I found that her concerns shifted from her previous anxiety about the consumption of alcohol to the growth of her foetus. Furthermore, I noted that in the second and third trimester the experience of foetal scanning and talk about big babies, which were aspects of her mid and late pregnancy experience, drew attention to how visible she felt as a larger pregnant woman. Like Nicola in Monologue 6 (see Section 6.7), who says that: "as a bigger girl you're always in the spotlight" (a direct quote), my analysis revealed that Vron described being "put on the spot" in instances where, for example, the consultant obstetrician accused her of eating too much sugar in the context of a foetal growth spurt.

I found that the stories the participants told about foetal size demonstrated how highly visible the women were as larger women in the context of foetal growth surveillance and societal supervision. These stories either focussed on the size of their 'bump', in which participants positioned lay people as critical of their abdominal girth and the imagined size of the baby within, or the results of growth scanning where comments were made about the size and anticipated weight of the baby. Some of the participants were directly informed by MHP they were going to have a 'big' baby. Moreover, some of the participants (e.g. Susie and Nicola) were also subjected to comments about the size of the foetal abdomen by MHP during growth scans. This point is illustrated by a quote from Susie who told a story in which she says her foetus has "got a fat belly just like its mum".

My analysis demonstrates that it is Vron's visibility as a larger woman coupled with the assumptions which were made about larger women's eating habits, had the effect

of rendering her as deserving of being singled out as a probable 'high sugar consumer' by the obstetrician. Further, I suggest that by positioning Vron's adiposity as the cause of the problem adds another layer to the moral jeopardy (Murphy, 1999) she encounters within this context. I also suggest that the high level of reported speech in Vron's stories demonstrated the intensity of the emotions she felt about the situation. From my analysis it also appeared that, in the context of the current 'maternal obesity epidemic', sugar seems to have taken on a status similar to other substances which are believed to harm the foetus in pregnancy such as tobacco and alcohol.

Overall the stories, which the women told about the size and shape of their foetus, demonstrated that, in the context of growth scanning and talk about big babies, the women became increasingly concerned about foetal growth. In this respect I found that the imagined size of the baby shaped their thinking about risk in childbirth. This is an important finding in that previous research with larger women has suggested that MHP may over exaggerate the risks associated with their pregnancies, especially in relation to the possibility of having a larger than expected baby and assisted birth or caesarean section (DeJoy, Bittner & Mandel, 2016). Furthermore, I suggest that these findings are especially significant in that women may be advised to undergo interventions due to the expectation that they will deliver a large baby (DeJoy & Bittner, 2015). My findings illuminate how Vron's experience of foetal growth monitoring, which she discovers may not be accurate due to her adiposity, nonetheless sets her on a path to early induction of labour as is demonstrated by her keenness to induce her labour. I will present findings in relation to how participants experienced the induction of labour in Chapter 8. In the next 2 monologues I present findings which illuminate another aspect of care which also shaped the women's approach to childbirth.

The anaesthetic counselling clinic

7.8 Monologue 14 - The anaesthetists: planting the seed

Because of the way our service is set up I see three quarters of all the women on the elective section list and 50% of the women in our so-called *High-risk Anaesthetic Counselling Clinic*. I would say that most of the women I see are not entirely sure why they are referred to the clinic, and a lot of obese women don't know that they're at higher risk of some kind of intervention, which is very unfortunate. So I have to very carefully broach the idea that they've been singled out because of their BMI, and of course for some women this is a deeply sensitive issue. The aim of the consultation is to provide a bit of explanation and to give them a chance to ask questions, and to plant seeds, as it were, of things that they might think about in the run up to their labour and delivery specifically.

In terms of explaining to women why they're seeing me, my philosophical approach is that, yes it's important to have an evidence base in terms of the quantitative stuff, but I think one also has to be a little bit careful about using that to be very definite with patients. So for this kind of advisory thing I use words like, you know: "the conventional wisdom, among anaesthetists who look after obstetric patients, is that a prim[58] with a higher body mass index is statistically much more likely to end up in theatre. So there's anxiety about whether an anaesthetist can deliver a quick and safe regional block in the event of an emergency caesarean section".

In women with a BMI of 40 we know from statistical evidence that they're twice as likely compared to a women with a BMI of 25 to need to go to theatre. But that's about the only statistic that I use because I'm quite reluctant to give precise statistics because I think they're very difficult to apply to individual women. So I summarise this information by saying that, if they were thinking that there would be no way they would want an epidural, then just have a wee think about what I've said. But it's their choice at the end of the day. So if they're thinking that they're not sure about having

[58] The term 'prim' is short for primigravida which describes a woman who is pregnant for the first time (Tiran, 2017).

an epidural, I try to just tweak their thinking a bit. But that's as strong as the advice would be. I'm very careful not to say: "we think you *should* have an epidural". Because I don't think the evidence is strong enough to make that kind of statement. I think it's good for women to know about that in advance but equally it's important to remain encouraging if they're planning to have a vaginal delivery.

Table 7.7 The anaesthetists: planting a seed

Narratives drawn on in this monologue		
Participant	Title	Theme
Alan (consultant anaesthetist)	*It's best to talk to women before something happens*	Risk
Alan (consultant anaesthetist)	*Planting the seed*	Risk
Angela (consultant anaesthetist)	*Women don't know why they've been referred to us*	Risk
Angela (consultant anaesthetist)	*Having a section does not make you a bad mother*	Taking responsibility

7.8.1 Commentary and discussion

My analysis of the interviews with anaesthetists revealed that, like the midwives and obstetricians, they were also highly concerned about offending larger women by raising the topic of weight. Both anaesthetists talk suggested that they feared the women would withdraw cooperation with the medical aspects of their care. Within their talk they also positioned women as unaware of the risks they may face in pregnancy, making the provision of information an important feature of the work they did in the *High-risk Anaesthetic Counselling Clinic*.

When analysing Alan's interview I noted that he tended to talk about risk in quite vague terms, using phrases like: "the conventional wisdom among anaesthetists", rather than drawing on some of the statistical information which seems to be highly prominent, especially in the CMACE/RCOG (2010) guideline and in the written information provided to women (see the next monologue). I understood from my literature review that the way that risk is communicated to women is believed to have an important bearing on patient decision-making (Alaszewski & Horlick-Jones, 2003), especially in relation to pregnancy where women's perception of risk can be

elevated beyond actual risk (Lee, 2014; Houghton *et al.*, 2008). Therefore, the way that Alan described talking to women about risk surprised me.

I constructed the monologue to try to capture some of the tensions which were prominent in the anaesthetist's interview talk. I was interested that Alan's positionality suggested he resisted providing women with more specific individual advice, saying: "the evidence is not strong enough" (in that it is generalising rather than specific). I also noted that, in the absence of more personalised evidence which he could rely on, Alan felt that the best option was to 'plant a seed' which he hoped would 'germinate'. Alan's approach may be viewed as gentle as he spares women the statistical information which they may find more alarming, however, it is only half of the story as it fails to capture how the seed the anaesthetist plants acts on the women who attend the clinic. In the next monologue I try to capture Nicola's consultation with an anaesthetist shapes her decision-making in relation to childbirth.

7.9 Monologue 15 - Nicola: doing what they recommend

Since I got over the early pregnancy sickness I've not really had any problems at all. I've had quite a few appointments with different people for tests and scans. The diabetes test was negative, but apparently I need to have it done again next week because they're worried that there might be extra fluid around the baby, or something like that. I suppose I feel like I have to just go along with it all, you know, I've never been pregnant before and I just think that they're the professionals, so I just trust what they say.

I saw the anaesthetist yesterday. Her opening line was: "do you know why you're here?" Actually I didn't, so she had to tell me. Apparently, if I need pain relief in labour then it's better to have it sooner rather than later, I think it's something to do with it taking longer to get round my system because I'm bigger. I wasn't really sure about the epidural, and I hadn't really thought about it before I saw her, but she said that if I need a C-section then it's much easier if the epidural's there.

I don't like the thought of an epidural, I've heard stories where people never walk again, but I know that's the worst that can happen. I don't like the idea of not being

able to feel your legs or walk, even for a short time. But the anaesthetist said that you still feel the contractions, which is reassuring because at least you know when to push. So that feels a bit better. She looked at the veins in my hands and arms and then asked to look at my back and she showed the trainee where they would put the needle in. That was it really; she gave me a leaflet and told me to think about it. So really it's my choice, if I choose to listen to them. As I say, I've not done this before, so I'm quite open about what's best to do, and when it comes down to it I just want to do the safest thing for the baby.

It's weird though, there's no information about bigger women having natural births, so I don't even know if it's possible or not. Let's face it, it's the professionals who tell you what to expect. So when they recommend you have an early epidural and you follow their advice you're never going to know whether you would have needed it or not. I suppose though, when it comes down to it, I just want him out as quickly and as safely as possible. At this point in my pregnancy I think that if I could do it all again I would rather be smaller having a baby, then I could have avoided all this.

Table 7.8 Nicola: doing what they recommend

Narratives drawn on in this monologue		
Participant	Title	Theme
Nicola	*Anything can happen*	Anything can happen
	Doing what they recommend	Doing what they recommend
Stories drawn on in this monologue		
Participant	Title	Theme
Nicola	*Do you know why you're here?*	Doing what they recommend/Anything can happen
	If I choose to listen to them	Doing what they recommend/Anything can happen
Motif		
Doing what they recommend/making sense of medical advice		

7.9.1 Commentary and discussion

OGTT and the big baby

This monologue is based on two of Nicola's stories about separate experiences of antenatal care which are not obviously linked but are related. In analysing these stories I noted that they offered Nicola little hope that her pregnancy would be without complications. It was also apparent from Nicola and the other women's stories that they were also cautious about negative results due to an expectation that they would become positive in the future. In this respect I found that repeated tests were not an unusual feature of the participants' experience, especially in relation to OGTT. In similar research DeJoy, Bittner and Mandel (2016) also note that negative tests were often repeated; however, the reasons for this are not discussed in the article. This finding seems to suggest that risk discourse, which conflates embodied largeness, GDM and high sugar diets, may have a bearing on this situation, especially with the assumptions which are made about larger women's eating habits.

As I discussed in Chapter 2, GDM is associated with larger babies (Heude *et al.*, 2012) and/or increased or 'excessive' weight-gain (Heude *et al.*, 2012; Warin *et al.*, 2012). However, the association of 'maternal obesity' and large-for-gestational-age babies is very much contested (Robinson *et al.*, 2003). And in this respect I found that all the participants drew on maternal obesity risk discourse in relation to OGTT, talking frequently about the risks of having a larger baby. For example, Angie told a story about a woman with GDM who had been informed by MHP with great certainty that her baby would likely weigh 13lb at term. Meanwhile, Anna and Susie like Nicola, told stories where they were surprised when the OGTT was negative in the context of their (over) weight. I noted that stories about larger babies seemed to increase compliance with OGTT testing and also appeared to increase tolerance for repeated tests when the OGTT was negative.

While Nicola appears to offer little resistance to the medical intervention she was offered she does however identify that her decisions were based on a one-sided argument, in that, she was not offered any information about the occasions when larger women require no medical intervention and experience fewer complications or less medicalised deliveries than expected. Nicola was not alone in questioning gaps

in the information proffered to larger women about pregnancy. This finding concurs with those of DeJoy, Bittner and Mandel's (2016) who also note that larger women want more balanced information about the larger body in pregnancy.

The High-risk Anaesthetic Counselling Clinic

I met with Nicola for her second interview the day after her consultation with the anaesthetist; therefore the experience was fresh in her mind. She had been given a leaflet about 'maternal obesity' and labour but said that she "would read it nearer the time". The story Nicola told about her consultation with the anaesthetist features the recurring motif: "do you know why you're here?" (see also Chapter 6). The question is used to begin a discussion with Nicola about why she has been referred to the *High-risk Anaesthetic Counselling Clinic*. Previous research has suggested that antenatal consultations with larger women are used as an opportunity to "promote" epidural anaesthesia as a method of pain relief in labour (Furber and McGowan, 2011: p.441). I was interested in how the women experienced this clinic and how attending the clinic shaped their decisions about childbirth. I found that when the participants talked about epidural anaesthesia, rather than talking about it in terms of pain relief, the participants articulated their fears about not being able to move their legs, and therefore, not being able to be actively involved in their labour.

In analysing Nicola's stories about mid and late pregnancy I noted that she drew on risk discourse to position herself as in need of expert advice and expert medical attention. I suggest that Nicola's positioning of herself as a first-time pregnant woman makes clear that she feels somewhat dependent on MHP advice and that she will "do what they recommend". Indeed, my analysis revealed that 'doing what they recommend' was a motif running through her pregnancy. I noted that Nicola also talked about decision-making in terms of "if I choose to listen to them" which, I suggest, draws attention to the one-sided nature of the information she had been given. Therefore, my analysis reveals that Nicola perhaps recognises that, in this context, the notion of 'choice' is a fallacy.

My analysis of Nicola's experience of the *High-risk Anaesthetic Counselling Clinic* demonstrates that the discourse of foetal risk was mobilised to help her make a decision. In this context she makes her decision based on "the safest thing for the

baby", demonstrating her positionality as a 'good mother'. As I drew attention to in Chapters 2 and 3, previous writers have suggested that when women's (over) weight becomes the focus of care, discourses of mother-blame may be evoked to position larger women as 'irresponsible' in relation to the perceived risks to their unborn child from maternal body size (Bell, Mcnaughton & Salmon, 2009; Keenan & Stapleton, 2010; McNaughton, 2011; Warin *et al.*, 2011; McPhail *et al.*, 2016). In the next monologue I illustrate how discourses of maternal blame are drawn on in the context of obstetric decision-making and the larger body.

The antenatal ward

7.10 Monologue 16 - The obstetricians: obstetrics is just one big grey area

Dealing with high-risk pregnancies does affect your practice, particularly with things becoming as litigious as they are today. Every time you turn on the TV they have adverts encouraging people to sue for the slightest things. But, the thing is, obesity does increase women's risk a lot. It makes my job physically and technically more difficult, and because of this you're much more likely to maybe end up in a situation where you're having to defend yourself, through no fault of your own really. I think sometimes people think we're miracle workers and they can just do what they like and we will make everything all right. People just think that they're entitled to a healthy baby without taking any responsibility for their own health and we're the ones that get left picking up the pieces.

Let me give you a couple of examples of how difficult my job can be. The first has a happy outcome and the second not so happy. Both of them were really complex cases the maternity team had to deal with. The first one involved a woman who could barely fit on the bed. This woman had type 1 diabetes so we were worried about risk of infection with her. She was 32 weeks and her membranes had ruptured, increasing the risk of ascending infection. On top of that we were having a real job monitoring the baby. We couldn't work out how the baby was lying and we needed to know whether it was breech or not. We were trying to scan her, which was almost

impossible, and the frustrating thing was that the woman didn't seem to realise how important it was for us to be able to monitor the baby.

With obesity a lot of it depends on where the fat is. So if a woman has central obesity and has a lot of fat round her middle this makes things much more difficult for us. Anyway, she was saying: "oh, you'll have a hard job finding him, he's always hiding". I just wanted to say to her: "the baby's not hiding, it's just that you've got so much fat on your abdomen that we can't find the baby, so we can't monitor the baby effectively". Anyway, the consultant said to my colleague: "how's your scanning skills?" I was almost sick with relief that I wasn't going to have to scan her, because the chances of missing something trying to scan through all that fat are so high, and if you can't see what you're doing you feel like your competence is being challenged. Women just expect that we can get through all that fat but we can't.

The second case happened at Christmas time. The mum wasn't very well and she was still pretty early in her pregnancy, but early delivery was looking likely. Problem was that as with all very premature babies we need to give steroids to improve the baby's lung function but we can't do that before 24 weeks. We were pretty sure from scans that this was a well-grown baby which helps us make all our decisions about when to deliver and when to give steroids. As it turned out the baby didn't get the steroids because we couldn't prolong the pregnancy long enough and the baby was delivered. However, rather than being a well-grown baby it was tiny and all the scans had been completely inaccurate. Had we given the baby the steroids we would have given the parents false hope. Ultimately, we had to withdraw care from the baby.

So one of the important things to realise about obstetrics is that it's just one big grey area. There's no black and white to it and you have to make the best decision with the information you have at the time. If you can't get good information to hang your hat on, then you're essentially leaving yourself indefensible. The problem is that obese women just don't seem to have any idea about the risks to themselves and their babies from being obese when they're pregnant. They've also no idea how difficult they are to look after in pregnancy, or the risks they face from serious complications like shoulder dystocia which can be a risk when a woman's got a big baby on board.

If they were patients anywhere else in the hospital they would be sent away to lose weight. But we can't do that: we've just got to try our best to manage all the risks.

Table 7.9 The obstetricians: obstetrics is just one big grey area

Narratives drawn on in this monologue		
Participant	Title	Theme
Lucy (obstetrician)	*Accessing the baby*	Body as a barrier to the foetus
Eileen (obstetrician)	*Litigious society*	Taking responsibility
Lucy (obstetrician)	*It's so difficult to estimate the size of the baby through all that fat*	Body as a barrier to the foetus
Amy (charge midwife, labour ward)	*Healthy baby entitlement and miracle workers*	Taking responsibility
Lucy (obstetrician)	*People have to know risk*	Taking responsibility
Stories drawn on in this monologue		
Participant	Title	Theme
Eileen (obstetrician)	*Finding the baby*	Body as a barrier to the foetus
Eileen (obstetrician)	*You couldn't put any money on it! Parts 1 and 2*	Body as a barrier to the foetus

7.10.1 Commentary and discussion

Body as a barrier to the foetus

When conducting interviews with the obstetricians and anaesthetists I noted that their talk about caring for larger women communicated a sense of being trapped, in that they had no option other than to cope with the challenges they faced with larger embodiment (see also Monologue 12). I also noticed that the term 'miracle worker' appeared in both midwifery and obstetric stories. In this monologue I aim to portray how practitioner experience of dealing with larger bodies shaped how they felt about the women they cared for. The monologue draws on the theme of 'taking responsibility' which was discussed in Section 7.6 to extend further what has been said in relation to how obstetricians viewed larger women's bodies as forming a barrier to the foetus. The monologue is based on two stories told by Eileen and also draws on the 'miracle work' narrative which appeared in Amy's interview (charge midwife, labour ward). At the beginning of Eileen's interview I asked her what prompted her to take part in the research. Her response to this question revealed that

she was fundamentally concerned with the increased numbers of larger women with 'high-risk pregnancies'. Her main concern with this situation was that she felt she was at higher risk of litigation should any negative outcomes occur.

Existing medical and midwifery literature highlights that MHP feel frustrated about the difficulties they face in monitoring larger women's foetuses, with maternal abdominal fat being identified as particularly problematic in terms of assessing foetal growth and development (Singleton & Furber, 2014; Furness *et al.*, 2011; Schmied *et al.*, 2011). Conversely, feminist scholars highlight that during obstetric examinations women often feel reduced to body parts: as the obstetrician's focus is solely on the foetus, pregnant abdomen, and test results (Martin, 1989). The objectification of larger women's bodies in the context of MHC has been given scant attention in recent healthcare literature, and therefore in an attempt to highlight this issue further, in this monologue I draw on obstetric stories within the theme 'body as a barrier to the foetus' and examine how notions of responsibility and blame serve to Other larger women in the context of MHC.

The central conflict in obstetric stories within the themes: 'taking responsibility', and 'body as a barrier to the foetus', draws attention to obstetric decision-making and adiposity. As discussed in Section 7.6 (where the obstetrician fears losing women's cooperation), I found that, especially in stories about clinical decision-making, the obstetricians communicated a sense of feeling trapped in that, unlike the bariatric surgeons who were able to insist that their patients lost weight prior to undertaking medical procedures, the obstetricians had little choice but to provide care for women irrespective of their adiposity. In the monologue the pressure the obstetrician feels contrasts with the ignorance of the woman: who jokes that her baby is hiding. By positioning the woman as 'ignorant' the obstetrician draws on neoliberal framings of obesity (which she does throughout the interview) to cast the women as irresponsible (i.e. in failing to seek and follow health guidance to reduce their weight before pregnancy).

I suggest that my findings in this area support Douglas' (1992) argument that notions of risk are conditioned by culture and "shaped by social pressures and notions of accountability" (Price, 1996: p.88). With the obstetrician unable to see the baby she

is working somewhat in the dark, as she says: "obstetrics is just one big grey area". Eileen was very candid about her personal fears of litigation: a fear which appeared to act as a constant reminder of the consequences of making a mistake in terms of her medical registration. Fear of adverse outcomes has been identified as a key motivator in the recent trend in over-medicalising low-risk births (Healy, Humphreys & Kennedy, 2016b). However, in the context of 'maternal obesity', Eileen's stories reflect her frustration with larger women's bodies in that they represent an unnecessary and preventable barrier in terms of being able to access information about the foetus. This situation impacts on her ability to make clinical decisions: a difficulty compounded by the ever-present threat of litigation which is a facet of risk society (Beck, 1992; Annandale, 1996), and societal expectations about the management of risk (Giddens, 1990).

7.11 Conclusion

In this chapter I have presented findings which demonstrate how larger women's interaction with the wider maternity team shapes their experience of mid and late pregnancy. The findings illuminate MHP positionality in relation to larger embodiment and also demonstrate how these framings configure their interactions and practices with larger women. The findings highlight that higher BMI women (as they are often termed by the MHP) are not viewed and understood as a homogenous group, and several factors shape the assumptions which are made about larger embodiment. This aspect of the findings demonstrates the complex nature of the assumptions and interactions which take place in antenatal consultations. I will conclude this chapter by drawing attention to some of these as they relate to larger women's experiences of childbirth and the postnatal period.

The narrative of 'Fatness as socially contagious' appeared consistently across the MHP data, and in mid to late pregnancy I found that this narrative acted on women's pregnancies in that it configured several MHP practices which draw attention to larger women's adiposity (e.g. OGTT and foetal growth-scanning). Although previous research has highlighted the complexities of raising the topic of weight with larger women, none have so far discussed how biomedical technologies are used in this process.

As discussed in Chapter 6, my findings relating to experience of mid and late pregnancy illuminate that MHP framings of larger women very much depend on whether MHP wish to 'target women' (alert them to their adiposity) or 'provide balance' (protect women's feelings). This finding is important as it helps to draw attention to the ways that maternal obesity and anti-obesity discourses operate in MHC spaces. Throughout the chapter I have highlighted several of these practices which I argue can be viewed as serving an institutional disciplinary purpose. These range from the commonly used phrase: do you know why you're here? To practices designed to "get the message across" whereby the obstetrician disseminates maternal obesity risk discourse via larger women to the wider community, and practices where women are asked to take responsibility for their own adiposity i.e. "please lift up the layer of fat?" These are important findings which have significance in relation to how larger women's bodies are 'managed' in the context of MHC.

Some of the most significant findings relate to those which demonstrate how the politics of visibility (Tischner & Malson, 2008) function within MHC spaces where large bodies are highly visible but simultaneously silenced by the assumptions MHP make about larger women's lifestyles. Enmeshed within this aspect of the analysis is the much-contested subject of GWG which seemed to dominate mid and late pregnancy narratives. Again in this chapter we see that the highly visible nature of the larger body also renders women (in)visible due to the reductionist approach taken by MHP who tend to view them through a deficit model. The findings demonstrate that framing women in terms of deficiency tended to reduce them to 'faulty lifestyles' attracting various practices which the women found demeaning including the provision of basic nutritional advice. In relation to conversations about lifestyle issues, although I found that MHP embodiment had a bearing on the conversations larger and slimmer MHP had with larger women, I found that, irrespective of MHP embodiment, the assumptions made about women's lifestyles tended to be similar, as was the type of advice women were given in this situation.

My findings also suggest that as far as the MHP are concerned, BMI is a somewhat blunt instrument compared to a visual assessment of where a women's fat is in relation to preventing access to the foetus (i.e. 'body as barrier to the foetus'). This is

an important finding demonstrating that the intense interest in the growth of the foetus also has the effect of objectifying women by reducing them to body parts i.e. abdominal fat. Vron's experience of foetal monitoring stands as a powerful testimony to how the highly visible nature of her 'fat body' renders her a target for the accusations which the obstetrician makes about her consumption of sugar i.e. her (in)visibility. Similarly, the comments made by the sonographer about Susie and Angie's foetal abdominal measurements (and Susie's response to these comments) demonstrate recent changes in societal discourse which make the 'big baby' less desirable then previously (Jarvie, 2016). Anna's experience of weight-gain, and her subsequent efforts to control the size of her foetus, suggests that the intense interest MHP have in foetal growth places an unreasonable amount of responsibility for women to control the growth of the foetal body.

An important aspect of the findings presented in this chapter also relate to the ways risk discourse was operationalised to act on larger women. By paying close attention to the framings of the larger pregnant body I was able to identify that in situations where MHP felt most at risk in terms of accessing the foetus (i.e. the 'category one section'), they tended to frame women's bodies in terms of barrier and failure. This is an important finding in that it demonstrates a shifting of responsibility for complications from the MHP to the women; eliciting the cooperation of women in medical interventions which reduce risk to the obstetrician but may also cause iatrogenic harm to the women. This aspect of the analysis is further developed in the next chapter.

The most important findings from this chapter therefore relate to the way that institutional disciplinary practices operated on larger women's pregnancies in the second and third trimesters of pregnancy. This is the first study to demonstrate how the intense focus on maternal BMI, GDM and GWG combined with the technologies of foetal growth monitoring operate as institutional disciplinary practices. In this respect my analysis has drawn attention to how these practices place the responsibility for foetal growth firmly with the mother. These findings support and extend the writing of Warin *et al.* (2012) demonstrating how obesity discourse acts on the foetus in the context of MHC.

My analysis has extended the findings I discussed in Chapter 2 shifting the discussion from: what do MHP say is problematic about the larger pregnant body? To: how does the way MHP understand larger embodiment shape their practice in relation to the care of larger women? These findings are important contributions to knowledge; potentially helping to trouble some of the taken for granted practices which impact on larger women's experience of their pregnancies.

Chapter 8 Childbirth and the postnatal period

8.1 Introduction

Before going on to present the findings relating to childbirth and the postnatal period I begin this chapter by setting out an overview of the women's childbirth experiences based on the stories they told me about childbirth. I hope that by doing so I provide a context for the monologues, commentaries and discussion which follows.

I found the final interviews with the women traumatic. I had previously attended and assisted with childbirth during my nursing training. I had also listened to various friends relaying their birthing experiences over the years. In conducting the interviews with the women I was surprised at the level of medical intervention which they experienced. I also noted that the women were very keen to take part in the final interview and some of them cried when telling me about their childbirth experiences.

As with the previous findings chapters, I acknowledge my part in constructing the monologues which aim to capture and communicate the prominent themes found during the analysis of stories about childbirth. My positionality when analysing data about childbirth reflects my concerns about how power is distributed in the context of women's reproductive healthcare. My thinking in this area has been strongly influenced by feminist authors discussed in Chapter 3. In approaching analysis of stories about childbirth I was interested to shed further light on how risk discourse shaped both the women's and MHP experience. I had been particularly interested in DeJoy and Bittner's (2015) argument that weight-stigma contributed to the over-medicalisation of larger women's pregnancies (see Chapter 2). When approaching analysis I was interested in, firstly, how risk discourse was drawn on within stories about childbirth, and secondly, to what purpose it served. Bearing in mind that larger women's experience of childbirth has tended to be marginalised, primarily, the aim of my analysis of stories about childbirth had a focus on 'body as patient' aiming to understand from the women's perspective her birthing experience.

8.1.1 An overview of women's birthing experience

All of the participants described experiencing a highly medicalised childbirth reflecting the medical approach to their care (van Teijlingen, 2005). The analysis revealed that the stories the women told about childbirth drew on risk discourse to explain why various interventions were required. It was notable that none of the women talked about iatrogenic harm from these interventions. Furthermore, I found that the women took alternating positions in relation to how they framed their involvement in their own childbearing. At times they appeared to be passive recipients of their care (Chadwick & Foster, 2013); however, on occasions they actively sought intervention. Previous studies have suggested that when women think they are having larger babies they may request an elective caesarean section (Furber & McGowan, 2011). Moreover, the women's stories about late pregnancy suggested that when foetuses were suspected of being larger than expected, women were not only keen to induce labour early (e.g. see Vron's monologue in Section 7.7), but they were also willing to accept an early epidural in anticipation of clinical interventions (e.g. see Nicola's experience, Section 8.6).

When women sought medical involvement, analysis of their stories suggests that they did so because they were fearful of the complications associated with larger embodiment in relation to childbirth (e.g. they expected to require induction of labour), illuminating how risk discourse shaped their thinking in relation to childbirth. Moreover, as demonstrated in the monologues in this part of the chapter, during the final interview, all the women imagined alternative narratives for future pregnancies in which medical intervention was avoided.

All the women's labours were induced. Nicola was induced 12 days after her due date. Kacey, Angie and Susie's labours were induced around 37-39 weeks due to concerns about raised blood pressure. Vron and Anna, fearing their babies were getting bigger with every passing day asked for their inductions to be brought forward to their due dates rather than waiting until they were overdue. This finding concurs with similar research which suggests that when women are concerned about having a 'big baby' they may become anxious about childbirth (e.g. Smith & Lavender, 2011).

Although the women talked about having big babies and some of them were advised that their babies were large-for-gestational-age, only Angie had a baby which could be medically classified as macrosomic (i.e. ≥4,000g or 8lb 13oz) weighing 9lb 2oz. All the other women's babies were what is currently considered 'normal' or 'average' weight, ranging from 6lb 12oz - 8lb 2oz (3061g – 3685g).

The stories the women told in late pregnancy demonstrated that they had internalised the idea that their bodies would fail in some way, and therefore, they expected to have their labours induced at some point. I suggest that their experiences of MHC may have lowered their expectations about what their bodies were capable of in relation to labour, shaping their approach to childbirth. Furthermore, I noted the women were reluctant to think and talk about birthing during their pregnancies. Although previous studies suggest that larger women's birthing plans may be ignored or disrespected (e.g. Nyman *et al.*, 2010). I found that, with the exception of Anna who had extensively researched types of pain relief in labour, none of the women had made birthing plans. Moreover, the women discussed preparation for childbirth in terms of "not thinking about it" (quote from Susie), often discussing plans in terms of when their induction would take place. Nicola also said that from about halfway through her pregnancy she was convinced that she would need a caesarean section.

As I explained in Chapter 2, in relation to larger women, induction of labour is associated with increased need for further interventions (Sebire *et al.*, 2001; Bhattacharya *et al.*, 2007). In the general population, induction of labour is also associated with painful labours and assisted delivery (NICE, 2008). I found that the women experienced various further procedures following induction of their labours. Kacey, Vron, Nicola and Anna had an epidural/spinal anaesthesia followed by a forceps delivery. Furthermore, Vron, Nicola and Anna experienced further complications related to assisted delivery including tearing, cutting, extensive blood loss and infection. Angie and Susie also went on to have a spinal anaesthetic and a caesarean section. Angie experienced further complications, developing a wound infection and Nicola experienced difficulties during the postnatal period which left her feeling very low. Nicola, Anna, Vron, Kacey and Angie all framed birth as a traumatic event. Susie's narrative suggested that she was determined to demonstrate

‘good mothering’ in the context of anti-obesity discourse therefore she took a more stoic approach to her reflection on childbearing, focusing instead on ‘bouncing back’ after her caesarean section.

The research I discussed in Chapter 2, which explores larger women’s experiences of pregnancy, tends to focus on women’s interactions with MHP and their experiences of antenatal care rather than childbirth. Some of this research includes tabular details about birth outcomes (e.g. Furber & McGowan, 2011), but none of this research provides narrative accounts of women’s experience of childbirth and postnatal healthcare. In the general population women’s experiences of childbirth tends to be overshadowed by more material aspects such as the nature of interventions/complications, quality of care, and birth outcomes (Oakley, 1993; Beech & Phipps, 2008). However, Callister (2004) suggests that birth stories are often remembered vividly by women even decades after giving birth, suggesting that childbirth stories are important to maternal identity. Rubin (1984) also suggests that women often tell well-rehearsed stories detailing childbirth experience.

I certainly found that, although some of the women experienced ill health after childbirth, they were keen to take part in the postnatal interview. I also noted that all the women had identified specific aspects of their experience of healthcare which they wanted to foreground in the context of the interview. Childbirth is a multidimensional (Waldenström *et al.*, 1996) complex (Lavender, Walkinshaw & Walton, 1999) experience and I have found it challenging to ensure that the findings I present in relation to the experience of childbirth do justice to what were very long interviews and complex data. Therefore, what I present here are the key findings relating to how the women experienced the context of healthcare.

Induction of labour

8.2 Monologue 17 - Kacey: curtain wars

In the last 2 weeks of my pregnancy I’d been back and forward to the hospital with high blood pressure. I kept saying that I wanted to go home because I hate being in hospital. Anyway, because my blood pressure was high they brought forward my induction to 37 ½ weeks saying that the baby was better out than in. I wasn’t too

bothered about it because I'd had enough by then anyway and my feet were so swollen I was only leaving the house to go to the doctors. Not that any of them were much help, they just put everything down to your weight.

The ward where you get the induction has 6 beds with just a curtain in between so there's not much privacy. It was just my luck that I got the midwife who never smiles. I feel uncomfortable around her because I think she's looking down on me. Anyway, she's one of those ones who know how they like things. She has *every* curtain open at 7 o'clock in the morning: not just open but tied back. I kept closing the curtains and she kept coming back and opening them again and I realised with horror that I'm going to be in pain with everyone staring at me!

The girl in the bed opposite had been induced and was screaming in agony. She was crying and going back and forward to the toilet. She was asking to go to the labour ward, but there was no space so she wasn't allowed to go. She was on her own because it wasn't visiting time. I mean imagine making you go through all that on your own! Anyway, they just kept telling her to calm down. It was horrible to watch, I felt so sorry for her, and it made me more worried about people watching me in pain.

My induction worked really quickly and my waters broke after about 2 hours. I did my best to be as quiet as possible but eventually after bouncing on my ball thing for what seems like ages I just couldn't cope with the pain any longer. Well, I couldn't cope with the fact that I could hear them all listening to me, and whispering about me. I asked for morphine, go to sleep, and everything stops.

In the morning I was sent to the labour ward and they hooked me up to all sorts, a foetal monitor, a drip to make labour start and one with antibiotics for the infection I had because my waters had gone. I was scared. The only thing that helped with the pain was sitting up and bouncing on the ball, but once I was in the labour ward I couldn't do that, so I took the morphine. The doctors kept coming in and saying "you should have an epidural, just have an epidural" and I was like "I don't want one". Two of them had an argument at one point; one was shouting that they needed to give me a C-section because I was in so much pain and it was going to be ages yet.

The other one was saying: "no we're not giving her a C-section". They were so busy arguing that they wouldn't listen to me. Then they said: "we'll let you think about it". But it wasn't long and they came back in and they were just pushing me to do it. So I just said: "fine do what you want".

It took an hour to get the epidural in and I ended up regretting agreeing to it. I didn't like not being able to feel my legs, and I was uncomfortable because I couldn't move in the bed and the midwives wouldn't help so Craig had to keep trying to lift me up. After a while it stopped working and they said that I could get another one but I said no. They ended up giving me more morphine.

In the end I had a forceps delivery but at least I avoided a C-section. I know that next time I'll be doing what I want to do not what they tell me to do, well to an extent. I think with a first pregnancy you don't know what to expect and so you just do what they tell you. Next time I wouldn't have an induction so early, I'd want to just wait myself and be in labour at home for as long as possible, then they can strap me up to whatever they needed once I go in. That was the worst thing for me, not being able to move, not being able to walk around. I know a lot more about labour now so I won't be scared to tell them that I don't want an epidural or anything like that, and I won't back down.

Table 8.1 Kacey: curtain wars

Narratives drawn on in this monologue		
Participant	Title	Theme
Kacey	*Next time*	The struggle for control
Stories drawn on in this monologue		
Participant	Title	Theme
Kacey	*Swollen feet*	Containment/The struggle for control
	The induction – Part 1: curtain wars	Exposure/The struggle for control
	The girl in the opposite bed	Exposure
	I know people are listening	Exposure
	The induction – Part 2: epidural wars	Containment/The struggle for control

Next time	Containment/The struggle for control

Motif
Containing the body and the struggle for control

8.2.1 Commentary and discussion

Transgressing bodily boundaries

Kacey's monologue draws on the themes of 'containment', 'the struggle for control' and 'exposure', illuminating the ways induction of labour was experienced by the women on an antenatal ward. All of the women strongly disliked this ward and once they had spent time there they dreaded having to go back. The women complained about seeing other women in pain and hearing a range of sounds from behind closed curtains, which were embarrassing, and at times scary. For example, Vron like Kacey, was also upset hearing a woman in the next bed screaming in pain, saying: "I heard her waters go, she was on her own, it was awful" (a direct quote). Similarly, Angie, who was admitted there for blood pressure monitoring, was highly embarrassed when she overheard a midwife preparing the woman in the next bed for a vaginal examination. Furthermore, she was horrified when the same midwife appeared at the side of her bed, closed the curtains and started to prepare her for "a speculum examination". Angie challenges the midwife saying: "I only came in with high blood pressure" and discovers that the midwife has mistaken her for a woman who was bleeding vaginally.

Kacey's struggle for the control of her privacy is told through a story about the midwife who keeps tying back the curtains. Previous research has suggested that larger women express fear in relation to having their bodies exposed (Nyman *et al.*, 2010). However, Kacey's story about the girl who is screaming in agony demonstrates that she not only wants to prevent her own exposure, but that she also wishes to protect herself from having to view and hear other women's experiences.

In the current research I found that the women's stories illuminated the Western cultural mandate which women confront during pregnancy and childbearing which urges them to retain control over their emotions and bodies (Lupton, 1998; Longhurst, 2001). The sounds and disturbing images of pain and bodily leakages,

which Kacey, Angie and Vron describe, demonstrate the ways that the labouring body transgresses boundaries, displaying publicly a loss of control (Longhurst, 2000, 2001). In the admission ward there are also consequences when bodily fluids violate a boundary as Angie's stories about vaginal bleeding and speculum examinations demonstrate. Meanwhile Kacey's story, in which the midwives urge the woman who is screaming in agony to "calm down", also reinforces the cultural ideal of the emotionally contained and boundaried labouring woman. Therefore, the midwife's actions serve to demonstrate to Kacey that bodily control is expected, and transgressions are not welcome or tolerated.

Bearing in mind the difficulties that women may experience in relation to the control of their bodies in the context of childbearing, I want to suggest that the context of Kacey's induction may have had a bearing on the outcome of her induction. Her story illustrates how the sense of exposure, which she clearly articulates when she says people are "listening to me, and whispering about me" (a direct quote), may have influenced her decision to ask for the pain relief which she implicates in having a bearing on the progress of her labour ("I asked for morphine, go to sleep, and everything stops"). Importantly, the story Kacey told me about her induction draws attention to how the environment Kacey labours in, rather than the failings of her body, are perhaps implicated in the lack of progression of her labour.

Exposure

Kacey's stories demonstrated that she sought the solace of having her partner and mother with her during the induction procedure; however, as demonstrated in the monologue the 'one visitor at a time' policy meant that she had to ask him to leave so that she could spend time with her mother which made her feel guilty. In this respect I found that all the participants struggled to understand the restrictions on visiting which were in place on the antenatal wards. These restrictions meant that, although partners had more extended visiting times than other visitors, they were asked to leave after visiting hours leaving women in early labour alone overnight.

DeJoy, Bittner and Mandel's (2016) findings suggest that larger women feel self-conscious in healthcare contexts and in this respect I found that the women tended to seek the comfort of partners and family members who they felt loved and accepted

them (and their bodies). In the current study I found that when the women were left alone they often felt particularly exposed to potential criticism from onlookers. Therefore, when the antenatal ward appeared in stories it was usually characterised as a place where women were likely to feel exposed both physically and emotionally.

Another issue which visiting restrictions illuminated was that the women were highly aware of their status as first-time mothers, and therefore, sought comfort from other women who had experienced childbirth (Edwards, 2005). Angie's story makes this point in that she says: "they're not my visitors, they're my family […] I need my mum here because she's done it four times, so I need her knowledge". Nicola meanwhile says: "it was visiting time, so they had to go at 10 o'clock or whenever it was, so that was quite hard being on your own in a ward when your contractions […] are coming and going and you've never experienced it before" (all direct quotes).

Containment

The theme of 'containment' was an important theme throughout Kacey's interview narratives. In late pregnancy swollen feet, which prevented her from wearing shoes, and the breathlessness she experienced from mid pregnancy onwards meant that she was unable to leave her home other than to attend the hospital. From her interview narrative it was clear that the discomfort she experienced towards the later stages of her pregnancy combined with the suggestion that the baby was "better out than in" shaped her thinking about the early induction of her pregnancy.

Analysis of Kacey's story 'The induction – Part 1: curtain wars' demonstrated how power little control she felt she had during the induction process. The story depicts that once she was on the labour ward she was confined to bed and was unable to remain upright or to use her ball; both of which she previously identified as helping her manage the pain. Therefore, once "hooked up to all sorts" she was contained by her hospital bed and lost her ability to manage her pain. It is well recognised that placing women in the recumbent position is associated with various negative outcomes including increased pain, and prolonged labour (Jansen *et al.*, 2013). Kacey is also prevented from eating and drinking, and intravenous fluids and medications enter her body without her control. Her contractions are monitored and displayed publicly via continuous cardiotocography (CTG). And it is evident from

her story that she feels she has lost a sense of control over what is happening to her body. Furthermore, Kacey's monologue contains verbatim quotes about the point she agrees to the doctor's repeated suggestion that she has an epidural, making clear that she was somewhat worn-out by the situation: perhaps leaving her vulnerable to repeated suggestions that a caesarean section might be needed (DeJoy, Bittner & Mandel, 2016).

Once she is unable to move her legs Kacey struggles with even moving around in the bed. Nyman *et al.* (2010) suggest that women may adopt the sick role during childbirth, and therefore, when larger women's care is highly medicalised it may make it even more difficult for them to retain a level of autonomy. Certainly, in the cold light of day when Kacey reflects on her experience of childbirth during her interview, she identifies being confined to bed by biomedical technologies as an issue for her. In her future imagined labour she avoids being "strapped up" and retains the ability to move around autonomously to deal with her pain more effectively.

In the following 2 monologues I contextualise aspects of Kacey's birthing experience in relation to her decision to agree to an epidural anaesthetic. These monologues depict how fears of the worst-case scenario (which I have discussed at various junctures) are experienced by the anaesthetist and a labour ward midwife, both of whom frame practices in relation to the larger body from contrasting viewpoints. Again, these monologues evoke notions of targeting and balance; features of 'The label of maternal obesity' which were prominent in the community, midwife monologues presented in Chapter 6.

The labour ward

8.3 Monologue 18 - Angela, consultant anaesthetist: the worst-case scenario is always at the back of our minds

We always ask high BMI women to consider having an early epidural in labour. The problem we face though in talking to women about early epidural is that we're going against what everyone else is saying, "oh you don't want to have an epidural: it's

bad!" And we're going in and saying, "have an early epidural as soon as you go into labour". So it's difficult because sometimes women are not even prepared to listen to what we've got to say: we're like the bad people who want to stick needles into them. When really what we're saying is "think about having an early epidural, because once the epidural is in and working, we can extend it safely and quickly for any kind of procedure if it's needed".

At the back of our minds is the category one section, which is 30 minutes to get baby out. Imagine the scenario – it's an emergency, and it's taking too long to establish a regional anaesthesia, and you only have this small window. If you can't do it quickly enough then your fall back line is a general anaesthetic.

The problem with general anaesthesia in pregnancy is that we know pregnant women are *much* more difficult to intubate and high BMI women even more so. The thing that terrifies an anaesthetist at an emergency section is that you will have a failed intubation and the woman desaturates and becomes hypoxic. It's a horrible situation to be in and if you're rushing someone into theatre and you know that you need more time to get the spinal anaesthetic in, which sometimes we do with high BMIs, then you're under a lot of pressure. Which is difficult, because at the back of your mind is the potential catastrophic consequences of a failed intubation. It might be that the baby gets a bit hypoxic, but the worst-case scenario is that you end up with a dead baby and a brain-damaged mother.

Of course it's not like babies are dying every week, but the thing is, you read the confidential enquiry reports, and you see the deaths related to anaesthesia. I can't remember what they were in the last one, but certainly the one before that, 6 women died, and they tended to be the high BMI women. So in 3 years, in the whole of the UK, 6 women died because of an anaesthetic problem and the majority of them were high BMIs. We have a good risk management system here, so we have to read through these stories of the near misses and things like that. Once you've read these stories they're always in your consciousness: this could happen, and that could happen. So they probably make it sound worse than it actually is, you know, because it's not common, but you can't discount the fact that this could happen. You just never know, it's not necessarily the recipe for a contented working life, but then it's

not like I'm going home and not sleeping either. We just have to have the dreadful outcomes in the confidential enquiries in the back of our minds because if we don't then we're not going to prepare for it.

Table 8.2 Angela, consultant anaesthetist: the worst-case scenario is always at the back of our minds

Narratives drawn on in this monologue		
Participant	Title	Theme
Angela (consultant anaesthetist)	*The worst-case scenario*	Risk
Angela (consultant anaesthetist)	*Having a section does not make you a bad mother*	Taking responsibility
Angela (consultant anaesthetist)	*Mixed messages*	Risk
Angela (consultant anaesthetist)	*It's always in the back of your mind*	Risk

8.3.1 Commentary and discussion

In Chapter 2 I discussed the obstetric emergency of shoulder dystocia as a potential complication associated with large babies (see Section 2.6.4) and caesarean section (see Section 2.7.3). In relation to the findings from the current study I found that talk about the complication of shoulder dystocia appeared in Beth, Eileen, Lucy, Sarah and Emily's interviews. When midwives and obstetricians talked about this complication they tended to represent it as 'the worst-case scenario'. However, in the anaesthetists' interviews I found that the 'category one section' was the most feared emergency situation which required the anaesthetist to quickly access to air passages, spinal fluid and veins. I found that stories featuring the worst-case scenario were dominated by 'what if' thinking (Stafford, 2001) with a high degree of focus on the prevention of stressful emergency situations.

The most revealing aspect of the narrative drawn on by the anaesthetist in this monologue was that, although the narrator acknowledges that the worst-case scenario is an extremely rare event, it is nonetheless an omnipresent aspect of her subjectivity. The tendency to expect the worst-case scenario has been termed the '0.1% doctrine' (Kotaska, 2008), describing situations whereby attention is turned to adverse

outcomes rather than positive ones, leading to ‘risk magnification’. Sociological literature suggests that this situation has been influenced by advances in modern technologies which have created a culture where there is little tolerance for risk (Beck, 1992). Some authors suggest that this is especially so in relation to childbirth (e.g. Coxon, Sandall & Fulop, 2014; McGlone & Davis, 2012; Johanson, Newburn & Macfarlane, 2002). This is based on the expectation that all medical problems can be dealt with using technology (Giddens, 1990), this results in a perpetual state of anxiety (Beck, 1992).

Studies suggest that both doctors and patients may seek to reduce anxiety through seeking to gain control in ‘risky situations’ (Burton-Jeangros *et al.*, 2013). My findings suggest that the early epidural may represent an important means to deal with the anxiety which the potential category one section promises. It is the women however, who are faced with the responsibility of making a decision about whether to consent to an early epidural. In the next monologue the journey through maternity care reaches the labour ward where MHP stories and narratives draw on the notion of ‘the worst-case scenario’ and the theme ‘body as barrier to the foetus’; revealing in more detail how women’s bodies are framed in labour ward stories.

8.4 Monologue 19 - The midwives: the slippery slope and the conveyer belt to the theatre

I know that we should approach high BMI women with the expectation that they can deliver without any intervention, but in practice I don’t think that we do, and the reality is that they do get labelled a little bit. So once ‘BMI 40’ goes on the whiteboard I do feel like you're almost putting the woman on a path before she's even had something happen to her. You know, *labels stick*, and by the time a woman arrives in the labour ward she’s had the high-risk label drilled into her and she’s already thinking, “I’m not going to be able to do this”.

The other thing is, I don’t know, sometimes in this hospital, for some strange reason, midwives defer so much to the medical staff that I feel it’s almost obstetric nursing rather than midwifery. Especially the less experienced midwives, it just takes one wobbly moment and they’re asking for a medical opinion, and before you know it the

woman's on the conveyer belt to the theatre. I do think midwives are still advocates for women, but sometimes they let the medical staff make the decisions. The other thing about the label of obesity is that, in the labour ward, the minute a bigger woman comes in the anaesthetists come poking about your notes looking to see whether they think they might be needed later on. So sometimes I feel that it's a bit of a tug-of-war to keep the medics away.

But actually, I really hate the notion of giving someone a path to go down, because care should be tailored for the individual, and I am a great believer that we shouldn't be necessarily sticking high BMI women on a red pathway. Just because they're overweight doesn't mean to say these women are immobile, you know - they maybe go walking every single day or maybe they're actually even a fitness instructor. Also the skinniest of people can be the unhealthiest people that you'll ever meet. So weight is not a true indicator of health or necessarily an indicator of labour complications. I hate to think that the label of high-risk puts midwives off so that they don't provide normal midwifery care because of it. I've looked after numerous high BMI women and the majority of time they do deliver.

I've also seen the other side of the coin, that when something goes wrong, it goes wrong! And when it does it tends to be a much scarier process and the outcomes can be very different, so midwives always have that in the back of their minds. Also I think that once that 'BMI 40' goes up on a whiteboard the midwives expect to find a woman who's going to be immobile and really difficult to move. They're also going to expect that it's going to be difficult to try and get a CTG monitor on, so it's really difficult to pick up the foetal heart. I mean these are great machines but they're also a bit of a security blanket and it's drilled into midwives that if they've got more than 20 minutes of loss of contact then you should consider another method of monitoring and that's pretty invasive. Most midwives don't want to have to keep adjusting the CTG belts or be pushing them into a woman's abdomen. Sometimes I've seen midwives tie two belts together but I'm really wary of doing that, what would the poor woman feel? But really we've no choice because we have to monitor them in labour ward.

It's difficult, isn't it? BMI is only a number and I've seen loads of women with high BMIs who are the picture of health but then you can't treat a women with a raised BMI exactly the same as you would treat somebody who has no risk factors at all. It's a risk factor for a reason and in the labour ward we have to prepare for all eventualities especially with big women, so we have to make extra preparation to make sure we're ready.

Table 8.3 The midwives: the slippery slope and the conveyer belt to the theatre

Narratives drawn on in this monologue		
Participant	Title	Theme
Amy (charge midwife, labour ward)	*Wobbly moments and the slippery slope*	The label of maternal obesity
Amy (charge midwife, labour ward)	*Labels stick: the labour ward as a conveyer belt to the theatre*	The label of maternal obesity
Amy (charge midwife, labour ward)	*When it goes wrong, it goes wrong*	Women's bodies as a barrier to the baby
Amy (charge midwife, labour ward)	*The 'path' as a self-fulfilling prophecy: the label of obesity*	The label of maternal obesity
Amy (charge midwife, labour ward)	*The tug of war and the slippery slope*	Fat, fit, and healthy
Beth (midwife)	*It's a risk factor for a reason*	Fatness as socially contagious
Lesley (community midwife)	*It all takes a lot of time*	Women's bodies as a barrier to the foetus
Lesley (community midwife)	*Getting in*	Women's bodies as a barrier to the foetus
Stories drawn on in this monologue		
Participant	Title	Theme
Jodie (midwife)	*It's just a number*	Fat, fit, and healthy
Sadie (charge midwife, labour ward)	*All hands on deck*	Women's bodies as a barrier to the foetus
Beth (midwife)	*This is my job: I need to see what's going on here*	Women's bodies as a barrier to the foetus

8.4.1 Commentary and discussion

This monologue is based on the stories told by Amy, an experienced labour ward charge midwife. The monologue draws on the theme 'the label of maternal obesity',

which was prominent in the midwifery data, especially in stories about caring for larger women in labour. The theme captures how midwives understand the label of 'high-risk' in relation to both women's and MHP expectations of labour outcomes for larger women in the context of 'maternal obesity'.

Existing literature has drawn attention to what have been described as discriminatory practices in maternity settings, where assumptions are made about the capacities and limitations of larger women's bodies in the context of current guidelines (DeJoy & Bittner, 2015). Amy's stories suggested that in her eyes the practice of writing women's BMI on a whiteboard in the labour ward acted not only as a stigmatising label, but also served as a constant reminder of the low expectations labour ward staff had of larger women's bodies, potentially setting the woman on 'the slippery slope'.

Like other midwives who are sceptical of the efficacy of the BMI (e.g. Monologues 1 & 5), Amy's stories also made clear her reservations about any useful association between BMI and the performance of larger women's bodies in labour. I found that Amy drew on midwifery discourse highlighting the capabilities of women's bodies (e.g. von Teijlingen, 2005) and critiquing unnecessary medical intervention (Walsh & Downe, 2004; Walsh, 2010). My analysis also suggests that in doing so she sought to balance the effects of 'the label of maternal obesity', by situating herself as a protector of larger women in the face of over-medicalisation (i.e. the medics who 'poke around the notes'). However, I also noted that Amy was far from resolute on this matter, as this direct quote suggests: "you can't treat a woman with a raised BMI exactly the same as you would treat somebody who has no risk factors at all".

I suggest that to a degree this finding mirrors that of Heslehurst *et al.* (2013), who note that, when caring for larger women, midwives often feel torn. On one hand they are guided by the ideology that pregnancy and childbirth are normal physiological processes, which women's bodies can deal with (Downe, 2010; Walsh, El-Nemer & Downe, 2004; Johanson, Newburn & Macfarlane, 2002). On the other, they are also obliged to follow current guidelines restricting women's birth choices by involving medical input (NHS QIS, 2009; CMACE/RCOG, 2010). However, my findings suggest that this was far from a dichotomous situation, in that the position midwives

took in relation to larger women's bodies had an important bearing on whether they felt compelled to protect women, and often this was dependent on whether women were viewed as deserving of such protection, (i.e., 'fat, fit and healthy'). In some senses this finding relates to the positions midwives take on whether they see current guidelines as targeting larger women, and their need to provide balance to the medicalisation of these pregnancies, which was discussed in monologues 1, 2 and 3. However, in the obstetric ward settings, I found that notions of balance and targeting related very much to the *handling* of large bodies.

Amy's stories demonstrated that, although she sought to protect larger women from the clinicians, she also identified that larger women are viewed as 'unpopular patients'. In fact, a consistent finding across MHP data was that larger women's bodies were positioned as somewhat unwieldy and heavy: especially in emergency situations. Therefore, larger women who were viewed as heavy, or immobile tended to be framed differently from smaller or less 'unwieldy' women who are able to support the weight of their own bodies. In fact, I found that the MHP stories suggested that 'unwieldy' bodies tended to be viewed as more deserving of being targeted by the guidelines and the 'high-risk' label their pregnancy attracts.

Existing healthcare literature suggests that MHP have sought the provision of specialised equipment to help protect them from occupational injury, complaining that they need equipment to move larger women (e.g. Heslehurst *et al.*, 2011; Schmied *et al.*, 2011). However, my findings suggest that it was not just the heaviness of larger women's bodies that made them potentially unpopular, but that women who failed to fit into the equipment provided in the labour ward were also viewed as potentially problematic patients. However, as with 'the woman who could barely fit on the bed' in Monologue 16, it is noticeable in Amy's stories that, although the CTG equipment is clearly inadequate (in that it does not fit larger abdomens), she does not question why a remedy to this situation has not been sought. Therefore it seems that, rather than seeking to accommodate larger bodies (Longhurst, 2001, 2005a), midwives are often content with drawing attention to larger women as leaking (Shildrick, 1997) out of equipment: framing their bodies as unwieldy, and perhaps deserving of abjection (Kristeva, 1982).

This finding seems to suggest that the lack of provision of appropriate equipment which fits larger bodies may serve as a means of generating the emotions required to Other larger women, through feelings of disgust (LeBesco, 2004), serving as a means to prevent the social contagion which larger bodies represent (Douglas, 1992). Failing to seek to improve the fit of equipment seems especially important in light of the fact that poor foetal monitoring is highlighted as a factor in the 'wobbly moments' which are blamed for sending midwives to seek the opinion of the medics, which ultimately sets the women on 'the Path'.

The cascade of intervention

In her stories Amy used some interesting and revealing metaphors to describe what is often termed the 'cascade of intervention' (Singleton & Furber, 2014: p.106). Her stories outline how 'the path' i.e., *Pathways for maternity care* (NHS QIS, 2009) guidelines and 'the slippery slope' (i.e. the 'cascade of intervention') collude, leaving the midwives and pregnant women feeling they have little control of the situation. Existing literature highlights that midwives find it very difficult to maintain a sense of normality for larger women during labour (Healy, Humphreys & Kennedy, 2016b). On one hand, they are critical of increased medical monitoring during larger women's labour (such as continual foetal heart monitoring using scalp electrodes) (Scamell, 2015), while on the other hand they are also quite unsure of the implications of reducing monitoring (Simonds, 2002; Swann & Davies, 2012; Singleton & Furber, 2014).

Recent studies have demonstrated that, although midwives espouse the idea that women's bodies are capable of giving birth spontaneously, midwives are often "too easily unsettled by the operations of the organisation's risk technologies" (Scamell, 2015: p.19). I certainly found that Amy was critical of midwives who were overly keen on early intervention (based on fears of what might happen), an issue which has been discussed in healthcare literature (e.g. Abenhaim & Benjamin, 2011). Amy implicates the midwives, who wobble and defer to the obstetrician', as this placed women on 'the slippery slope'. Once on the 'the slippery slope', women are unable to avoid the iatrogenic factors (DeJoy, Bittner & Mandel, 2016) this entails: where

one intervention leads to another, placing women on ‘the conveyer belt to the theatre’.

Although Amy’s stories suggested that she questioned the efficacy of the BMI in terms of accurately predicting the level of complexity posed by larger women’s bodies, it was also clear that larger women’s bodies were nonetheless viewed as potentially ‘risky bodies’. My findings suggest that the position taken by midwives in relation to whether women are viewed as being targeted or are in need of protection from ‘the slippery slope’ may very much depend on the position they took in relation to whether larger women were deserving of protection.

The postnatal ward

8.5 Monologue 20 - The midwives: walking those legs off

When I’m looking after obese women I find myself constantly questioning: why are these women this size? I mean it must be a great big burden because everything takes so much more effort to do. I remember being pregnant and I remember I bent to tie my shoes and my belly touched my knees and it was like “oh!” A horrible feeling, like, I've never felt that before! But that’s just me. My husband calls me fatist, but I can’t understand why they would want to live in a body like that. So sometimes I think: “well, you’ve got yourself into this, so you have to kind of deal with it as well”. I think I do have empathy with bigger women to a point, because I know there are probably a lot of psychological things going on that’s made them get this size. So sometimes I feel bad when I’m jumping around doing all these things and they can’t even move around in the bed.

Bigger women know they need to move around, they know that they’ve got extra risk factors, so some of them will be up and about in no time and it's not an issue. Even so I do make a conscious effort with bigger women to make sure they're moving around. I suppose I would do this with all women who’ve had a caesarean section, but it’s always in my mind that bigger women have extra risk factors. So I’m always saying to them: "you need to get up and out of bed”.

I had this lady last week that wasn't a caesarean section she was a Neville-Barnes[59] and she had a BMI over 30. She had an infection I think, nothing major, and at one point I said to her, "you spend an awful lot of your day in bed so we really need to start getting you up and about and walking these corridors a little bit". I think we'd reached day three and she was just sitting there, you know, not much mobility going on. So I was saying, "I know you're here because baby's here, and you're on antibiotics, but your legs are swollen so you need to walk them off. You need to be up and down that corridor, you know - to the coffee lounge. I'll look after your baby: go there, and have a wee coffee". You know, it's very easy for anybody just to lie in their bed.

Table 8.4 The midwives: walking those legs off

Narratives drawn on in this monologue		
Participant	Title	Theme
Eileen (obstetrician)	*You need to be proactive*	Taking responsibility
Stories drawn on in this monologue		
Participant	Title	Theme
Sadie (charge midwife, labour ward)	*My body, your body*	The label of maternal obesity
Beth (midwife)	*Walking off your legs*	Taking responsibility
Beth (midwife)	*Getting them up and about*	Taking responsibility
Beth (midwife)	*Pandering to them*	Taking responsibility
Emily (consultant obstetrician)	*I don't know how women can cope with gaining weight*	Taking responsibility

8.5.1 Commentary and discussion

This monologue is based on an interview with Beth, a midwife who works in a postnatal ward. The monologue focuses on mobilising the large body and draws attention to the ways MHP embodiment appeared in stories where they try to make sense of larger embodiment. Within healthcare contexts, previous research with MHP has focussed mainly on how they feel about talking to larger women rather than exploring how embodiment acts in these spaces. For example, Schmied *et al.'s* (2011), and Knight-Agarwal *et al.'s* (2014) research highlighted that, in health

[59] Neville-Barnes are a type of obstetric forceps (Tiran, 2017).

consultations with larger women, larger midwives may feel hypocritical. Meanwhile, other research suggests that slimmer midwives may feel self-conscious about raising the topic of weight (Foster & Hirst, 2014). I found that most of the participants were keen to draw attention to their own practices relating to managing their weight. Therefore, the MHP positioned themselves as 'good healthy citizens' who practiced 'healthy eating' and went to the gym. By setting out this positioning they also revealed their own thinking in relation to how to manage their body size. As I will go on to explain, I found that the stories told by practitioners demonstrate that these framings act on the context of MHC through MHP embodiment and practices.

I found that stories featuring embodiment most often appeared in stories told by slimmer practitioners. Importantly these stories demonstrated how, particularly slimmer MHP, *embodied* neoliberal ideological framings of the large body which are implicit in anti-obesity discourse. And as I will go on to explain, these stories go some way to illuminate how MHP embodiment serves to Other larger women in the context of MHC.

In analysing Beth's stories - 'Walking off your legs', 'Getting them up and about' and 'Pandering to them', I was able to identify the expectations she appeared to have about (some) larger women in relation to mobilising. Her stories about postnatal care forwarded her efforts in trying to reduce the swelling in women's legs. On one hand, her efforts may be viewed as a feature of her professional responsibility, in that she aimed to reduce the risk of postoperative complications. However, in analysing these stories I noted that she tended to target larger women as in need of additional encouragement to mobilise. As Beth positions (some) larger people as unmotivated, implicit in her narrative is the belief that women who stay in bed all day are neglecting their responsibilities with regards to preventing complications associated with bed rest. This finding is not unique, and as I discussed in Chapter 3, previous research and critical authors suggest that larger people are commonly understood in terms of motivation, or the lack of it (e.g. Murray, 2008; Puhl & Heuer, 2009). Meanwhile, research carried out with health professionals has also identified a tendency to frame larger people as lazy and unmotivated (Teachman & Brownell, 2001; Schwartz *et al.*, 2003; Swift *et al.*, 2013).

Beth's interview narrative contained information about how her embodiment and imagination appeared to work together in a process of sensemaking. When telling me the story about woman who "can't move around the bed" Beth asked me: "why are these women this size?" Answering her own question, she says she imagines that it might be "a lot of psychological problems". Going on, she juxtaposes her own slim body with the type of body which she thinks represents a burden, contrasting her ability to move around, saying to me: "I'm jumping around doing all these things and these women can't even move around in the bed". I wondered at the time if by doing so she was trying to provoke empathy for the larger women. However, my analysis also reveals that she understands larger women as having the ability to control their own bodies, in that she says that they are *choosing* to stay in bed rather than moving around to reduce the swelling of their legs. This type of thinking is typical of neoliberal public health approaches to understanding 'obesity': encouraging people to make 'good choices' and take responsibility (Lupton, 1995).

Across the interviews, other MHP also drew attention to their own pregnant embodiment. They appeared to do so to draw attention to how they managed changes in their embodiment or to make comparisons about their own bodies in comparison to larger bodies. For example, in her interview Emily contrasted her own pregnancy weight-gain with that of larger women saying, "I just remember when I gained a kilo, and I just felt *ghastly* in pregnancy, and I cannot imagine how people feel gaining ten […] no wonder people feel miserable in pregnancy". Eileen told me that she was fearful of gaining weight during pregnancy, comparing her own efforts to suppress her weight-gain in pregnancy (see Monologue 12) with women who need to be "proactive and work hard" (a direct quote). Given that I found that MHP, irrespective of their size, all drew uncritically on anti-obesity discourse in their narratives and stories, even when they attempt to demonstrate empathy for women, these imaginings appear to serve as a means to symbolically Other larger women (Kristeva, 1982; Grosz, 1994, 1995; Shildrick, 1997). Furthermore, and most problematic, I suggest that, by situating larger women as *oppositionally* different from Self (Weis, 1995), there is little space for larger women to offer their own accounts of their embodiment and embodied experience.

8.6 Monologue 21 - Nicola: creating ‘bad mothers’

I was 12 days overdue when they took me in for the induction. I knew that I had to have an open mind about everything because I'd never done it before and I suppose I’d just braced myself for going into the hospital. As soon as I got to the labour ward I asked for an epidural because I was convinced that I was going to have a caesarean. And then being bigger as well I knew people would judge. But it wasn’t like that though, in the labour ward at least, they couldn’t have been nicer or more helpful. The anaesthetist talked to me constantly, explaining what he was doing and the midwife kept me calm. I really felt cared for. Even moving me when my legs were numb was okay, it was a bit of a performance and at first I thought: “how on earth are they going to do it?” But they just moved me on one of those hover mattresses.

I was so ill after the baby was born. I’d had all these problems with the epidurals, they couldn’t get the first one in and then later it came out. Then I had a spinal anaesthetic and forceps. I lost a lot of blood and then they thought I was developing septicaemia so I was kept in the labour ward overnight with a one-to-one midwife. I was hooked up to all sorts, and missed out on giving Oscar his first feed and bath. Rob did all that.

I think the hardest part of all of that wasn’t so much the trauma of it all but the way I felt in the postnatal ward. Looking back I really wish that I’d never been there at all. After all the fuss with all these people round me constantly, telling me what’s happening and being so nice to me, I was just sort of abandoned on this ward and nobody came and spoke to me at all. The first night was the worst, Rob had been ushered out the door and no one came near me. I was trying to look after a baby with a cannula in each hand and a catheter. I was tired and getting more stressed by the minute. I kept buzzing for the midwife and she said: “you don’t need to buzz for that, you just do it yourself”. Well, how could I when no one had even shown me where the milk and the bed sheets were? It’s like they want you to struggle. The next day was different though and a really nice girl, well I call her a girl she was quite young, she spent ages with me, told me where things were and just to help myself. It’s what I needed really, someone spending just even two minutes with me.

I've not been well since I had Oscar, it's been months really. Some of the feelings that I'd had in early pregnancy returned and I became a bit of a hermit. Eventually Rob told my mum how unwell I was and they persuaded me to see the doctor. I think that being bigger is what made me have the dips I had after I had him. Looking back I know that I bottled things up, I have a tendency to do that. Later on when I was feeling better I found out that one of my friends had felt as low as me, but she didn't mention it to me before I was ill; so I suppose it's the sort of thing no one talks about.

If you were to ask me if I'd do it all again and have another baby I would say no, definitely not, not as a bigger girl anyway. I don't want to lose loads of weight, which I know sounds a bit strange because everyone seems to want to be thin but I was always the biggest out of all my friends at school. So I've always grown up with that and accepted it as I think its part of who I am. I suppose being pregnant has changed the way I think about myself, not because I want to be smaller, but because I wouldn't like to be back in that situation. It's just that it must be a lot easier being an averaged sized person.

Table 8.5 Nicola: creating 'bad mothers'

Narratives drawn on in this monologue		
Participant	Title	Theme
Nicola	*Doing what they recommend*	Doing what they recommend
	Two minutes	Exposure/Seeking support
Stories drawn on in this monologue		
Participant	Title	Theme
Nicola	*The induction*	Doing what they recommend/Reproductive citizenship
	The epidural	Doing what they recommend/Reproductive citizenship
	I'm a bad mother	Exposure/Seeking support/Being visible/invisible
	You have to find our for yourself	Exposure/Seeking support/Being visible/invisible

It must be easier being an average sized person	Doing what they recommend

Motif
Doing what they recommend

8.6.1 Commentary and discussion

Due to her health Nicola was unable to take part in an interview with me as we had planned following the birth of her son. However, some months later she contacted me saying that she wanted to take part in the final interview. Nicola said she had felt very low for several months following childbirth and it was only with the help of her family and her GP that she was able to feel more like herself again. During the interview she most wanted to talk about her immediate postnatal experiences.

The stories Nicola told me about her childbirth experience suggested that she had taken very seriously the complications she might face during childbirth. In particular she expected to experience a highly medicalised labour which included a caesarean section. My analysis revealed that as she neared the end of her pregnancy her thoughts turned to spending time in hospital. As with Kacey's experience, it appeared that Nicola anticipated being in moral jeopardy (Murphy, 1999) in that she seemed resigned to being negatively judged in the context of the healthcare environment. I found it difficult to hear that she was surprised that the staff spent time with her and were "just so good to her" as this contrasted with her expectations (see also Monologue 6, Chapter 6).

Analysis revealed that other women also positioned the time midwives spent with them as a sign of whether they were worthy of support. In monologue 17 Kacey reads the unfriendly midwife as "looking down on her", suggesting she is sensitive to being judged in this context. Likewise, Anna told me a story about the midwives on the postnatal ward who "felt like your mum or your grandmother" who "sat on your bed and gave you 30 seconds more of their time". For Nicola, 'being good to her' also extended to the use of moving and handling equipment which other studies have identified as a particular thorny issue (for MHP at least) (see Section 2.8.6).

We already know from an earlier monologue that Nicola's stories about mid pregnancy suggest that she has noted the absence of information about pregnancy and childbirth for larger women. Therefore, I suggest that the positioning she takes in her childbirth stories demonstrate that, in the absence of alternative knowledges such as other larger women's experiential knowledge (or alternative medical knowledge), as a first-time mother she is open to doing "what they recommend". Furthermore, fearing negative judgement due to her adiposity she is perhaps keen to demonstrate that she is a 'good mother' in that she complies with the medical advice she has been given: asking for an epidural as soon as she arrives on the ward.

Although Nicola's stories suggested that she felt she received 'good care' while complying with the obstetric team, her stories from the postnatal period suggested that she felt "abandoned": becoming almost invisible once her baby was born. Looking more closely at stories from her postnatal period I was able to identify she also felt that, now her baby was no longer at risk, the staff were indifferent towards her. Importantly, Nicola's stories about her early postnatal period also revealed that she interpreted the care she received at that point as a reference point for understanding how she viewed herself as a mother. Nicola had an expectation that she would give her baby his first bath and feed, and she experienced deep regret that she was unable to do so. However, it was her inability to mobilise during the early postnatal period which was most problematic and left her needing reassurance that she was a 'good mother'.

Research elsewhere has demonstrated that early postnatal experienced may leave women feeling abandoned (Bhavnani & Newburn, 2010). In this respect, all the women in the current study who spent time on the postnatal ward also noted the contrast in the level of interest MHP showed them during the postpartum period. Furthermore, the women noted that, having been provided with so much information and been monitored so closely during pregnancy, they felt invisible following childbirth. Susie, for example, found it difficult to understand why her husband was prevented from staying and helping her during the time she was advised not to try to get out of bed or pick up her baby. This was particularly problematic, as there appeared to be so few staff available to help her.

Anna also told stories about the postnatal ward and these resonate with the other participants' experiences. She had experienced blood loss during her delivery where forceps were used to turn the baby who was a back-to-back presentation[60]. After delivery her baby was admitted to the neonatal unit for treatment of a suspected infection. The neonatal ward was some distance from the postnatal ward and Anna was shocked to find that she was expected to visit the baby alone despite feeling "massively tired and weak". Her stories also suggest that she felt the staff were refusing to help her because they thought she was lazy. Anna recounts almost fainting in a corridor and a passing doctor stopping to help her. The next time Anna visits the neonatal ward she asked someone to walk with her but finds the staff reluctant to assist. Anna told me that she was worried about fainting, saying: "if I collapse at 3 o'clock in the morning how many people will be there to help me"?

Angie told a very similar story to Nicola's in that, following her operation, she spent a day waiting for staff to help her feed and change her baby. When no help was forthcoming Angie phoned her mum who then contacts the ward. Angie like Nicola noted the contrast in MHP interest in her body, remarking: "it was really odd, one minute they're all telling you what to do, then as soon as the baby's born they just disappear". Previous research about larger women's experiences suggest that MHP complain that women are reluctant to mobilise during and following childbirth (e.g. Furber & McGowan, 2011). I found that in the postnatal period the participants were keen to mobilise however, the effects of spinal and epidural anaesthetics along with cannulas, catheters and other medical technologies made this highly problematic.

As I discussed in Chapter 3, authors have drawn attention to how women may be rendered invisible during pregnancy when the focus is on the foetal patient (Lupton, 2012c, 2013c). The postnatal period has as yet not been identified as an aspect of larger women's healthcare experience where there may be a tendency for women to be forgotten about or otherwise invisible. My findings suggest that, following a pregnancy where women are highly aware of their moral status as larger pregnant women, the support women receive (or the withholding of support) may have far

[60] A back-to-back presentation is when the baby's faces the mother's spine and is associated with prolonged painful labour and back pain during pregnancy (Coates, 2002).

reaching effects, shaping how women understand themselves as ‘good’ or ‘bad mothers’.

8.7 Monologue 22 - Susie: a ‘good mother’

After having such a good pregnancy my blood pressure went up when I was just over 39 weeks pregnant. My midwife sent me in to the hospital and they said because I was so near to my due date they wouldn’t start me on medication they’d just induce me. It took 2 pessaries to get things going. When she gave me the second one she said: “right then we’re gonna have to try you with another one, but we're gonna have to encourage you to walk, just go walk lots, go on the birthing balls and stuff like that just to encourage your baby to come down the way." Eventually when my cervix was 3 centimetres dilated they sent me to the labour ward and the anaesthetist came in and said: "do you want your epidural now or do you want to wait for a while?" I was like "can we wait a while?" I didn’t fancy being on the epidural for so long.

Everyone was really nice on the labour ward and they were fine with me trying on my own for a bit before having the epidural. When it got really sore the graph showing the strength of the contractions was still only at 37. The midwife told me that it could go up to 120! That told me it was time for the epidural, but just at that point the baby’s heartbeat started to slow and the consultant came in and said: “we don’t know what’s wrong with the baby but its heartbeat’s dropped and obviously we can’t take any chances”. By that time I was so groggy I was surprised that they asked me to sign the forms. Anyway, unfortunately, I had to have a spinal block because I hadn’t had the epidural early enough.

You’re numb for 24 hours so I was really surprised when they asked my husband to leave when I couldn’t even move myself up the bed never mind lift the baby up. I felt really helpless, especially when I had to keep ringing the bell and ask the midwife for something. You’d think they’d just give you a private room so your partner could stay. Anyway, once I could move again I made up for it and impressed the midwife when I managed my shower on my own, she said I should have waited for her but I just wanted to get on with it. Later on a young girl came in and they were saying to her: “you’ve got to move, you’ve got to do things for yourself”. Two of the auxiliaries carried her to the shower and the midwife said: “she’s not going to be

getting out of here any time soon". I don't know whether it's because I'm older but I just wanted to get on with it myself.

Now he's here, I'm going back to Slimming World®, I like the social aspect of it. I was thinking back on my pregnancy and about having more children. When I first saw the midwife and found out that I had to see the consultant I thought: "oh my goodness I must be really fat" later on I realised that they work it out on your height to weight ratio, so I'd only just come onto their radar. I think I'm not so interested in losing 3 stone or anything like that I just want to lose enough so that my BMI is under the cut off for obstetric care. I think that's 30, so if I can come in under 30 then that will be fine. Although I really enjoyed having all the extra scans, I did find trailing back and forward to the hospital difficult, and I don't know how I'd do that with an older child to look after. I felt a bit guilty getting the extra scans, nice as they were. I don't know, maybe if all mums got their weight down before pregnancy then everyone could have an extra scan not just the big mums.

Table 8.6 Susie: a 'good mother'

Narratives drawn on in this monologue		
Participant	Title	Theme
Susie	*Taking it from someone else*	Reproductive citizenship
	You can't count your chickens	Anything can happen
Stories drawn on in this monologue		
Participant	Title	Theme
Susie	*After a good pregnancy I get high blood pressure!*	Containment
	The induction	Containment
	The shower	Reproductive citizenship/Being visible/invisible
	Itching to get out	Reproductive citizenship/Being visible/invisible
	You need to move	Containment/ Being visible/invisible
	Coming in under the cut-off	Reproductive citizenship
Motif		
The 'good mother'		

8.7.1 Commentary and discussion

The 'good prenatal mother'

At the beginning of her pregnancy I found that Susie tended to draw on neoliberal discourse of healthy citizenship, and was therefore clear that her lifestyle was to blame for both her own and her husband's gradually increasing waistlines. Her experience of pregnancy and the postnatal period stood out from the other participants' in that, even prior to becoming pregnant, she was keen to demonstrate she was a 'responsible healthy citizen' (Shugart, 2010) and a 'good mother' (Lupton, 2012c).

At the time she became pregnant Susie was on the waiting list for fertility treatment and had been informed that she would not receive treatment until her BMI was below $30kg/m^2$. I suggest that this information was likely to have been influential in shaping her approach to preparing her body for pregnancy. In this respect I found that both Susie and her husband had been preparing their bodies for parenting through, not only weight-loss, but also by increasing their levels of physical activity and taking vitamin supplements. These practices demonstrate 'intensive parenting' which has already been discussed by several authors (e.g. Nash, 2006; Copelton, 2007; Lupton, 2011; Warin *et al.*, 2012; Lupton, 2012c).

At the point of her first interview Susie was attending weekly meetings at a commercial slimming club and been successful in losing weight. Prior to trying to access fertility treatment Susie identified that she and her husband enjoyed luxurious holidays, meals in restaurants and often relied on 'fast foods' after the end of a long day at work. I understood her interview narrative as being typical of the 'good mother' which several authors discuss as the Western cultural ideal for female self-sacrifice in relation to mothering (e.g. Copelton, 2007; Lupton, 2012a; Jarvie, 2016). At times during the interview I felt as if I was vicariously experiencing a slimming club meeting. Her interview narrative drew predominantly on current mainstream anti-obesity discourses which recommend 'healthy choices', typically a home cooked, low fat, low carbohydrate diet accompanied by increased levels of physical activity (Castle, 2015).

Susie's experience of MHC suggested that the MHP she encountered were happy with her efforts to demonstrate 'good mothering'. For example, at the beginning of her pregnancy she was spared the 'usual conversation' which the other women complained bitterly about. Instead her midwife apologised for mentioning her weight and encouraged her to make sure that she ate enough. However, by the end of her pregnancy it was obvious that Susie had reframed her positionality and, although she talked about going back to the slimming club, she also talked about only losing enough weight so that she could avoid obstetric care. Gone was the talk of being healthier and living longer. Instead Susie drew on another aspect of neoliberal anti-obesity discourse in which 'obese' people take precious resources from others (Saguy & Almeling, 2008). My analysis suggests that this shift in Susie's thinking had come about through the additional screening and interventions she had experienced as part of her pregnancy care.

The 'good postnatal mother'

The findings I presented in Section 8.6 drew attention to Anna, Nicola and Angie's experience of postnatal care suggesting that they felt they were somewhat abandoned to fend for themselves after the birth of their babies. Susie's experience, however, contrasted with both these women's in that she seemed to have less difficulty in accessing support in the postnatal ward. As I discussed in Chapter 7, one of the ways I suggest larger women may be 'disciplined' in the context of MHC is by having to take full responsibility for their own bodies and adiposity (i.e. lifting up their fat). In the labour and postnatal ward I found that mobility was a highly prominent feature of the women's stories which were replete with examples of the occasions when they felt unsupported or unassisted i.e. not being helped to move in bed (see Kacey), or not being assisted to walk when they felt faint (see Anna). Furness *et al.* (2011) has identified that midwives may underestimate the difficulties larger women face in living with a larger body, and therefore, women may feel unsupported. However, I found that the stories woman told about mobilising and immobility demonstrated that after childbirth larger women felt somewhat abandoned and unsupported.

When Susie told me the story about the girl who is half carried to the shower I suggest that she does so to contrast her own keenness to mobilise with that of the girl. Thus positioning herself as fully independent and mobile: avoiding placing

herself in moral jeopardy (Murphy, 1999). She makes the point that she takes responsibility for her body; she carries her own weight. Her stories contrast with those of Anna, who struggles with dizziness and feeling faint, and Nicola who must grapple with cannulas and catheters. I want to suggest that Douglas' (1966) writing on Othering sheds light on this situation perhaps providing a means to understand why Susie feels supported while the other women feel abandoned. These findings I suggest are therefore significant in relation to how the larger body is experienced in the context of MHC.

8.8 Conclusion

In Chapters 6 and 7 I drew attention to the ways that risk discourse was operationalised in terms of gaining women's consent for medical interventions. I also highlighted findings suggesting that larger women were somewhat (in)visible in the context of their antenatal care. In this chapter I have presented findings which illuminate women's (in)visibility in the context of childbearing. In this respect I found that, on one hand obstetricians' and anaesthetists' stories of childbirth depict the much-feared worst-case scenario of the category one section, while on the other are women's stories of exposure, containment and the struggle for control. This chapter has made more visible aspects of larger women's account of childbirth which would otherwise be rendered invisible due to the discrimination which people with larger bodies face in healthcare spaces (Longhurst, 2005a).

The intertwining monologues of the women and the MHP also demonstrate differences in the midwifery framings of the large birthing body and those of obstetricians and anaesthetists. In this respect I found that some midwives sought to protect women from 'the slippery slope' and the 'cascade of intervention' drawing on framings of women as 'fat, fit and healthy' to criticise the label of maternal obesity in terms of over medicalising some larger women's pregnancies. These findings mirror findings I presented in Chapter 6 which suggest that when pregnancies are labelled 'high-risk', community midwives felt that on occasions women needed protecting from the effects of risk discourse.

The findings presented in this chapter further suggest that the larger pregnant body is problematised in terms of providing a barrier to the foetus during childbirth and the

findings shed further light on how the targeting of larger women acts in the context of the larger labouring body. Binding together the monologues is the notion of the big baby which forms the basis of stories of the worst-case scenario i.e. shoulder dystocia and the category one section.

The findings I have presented in the last 3 monologues of this chapter depict the women's postnatal experience. These findings are significant in that, like early pregnancy I found that postnatal experiences have attracted little research interest, and this is particularly so for larger women. I am therefore, able to make a significant contribution to what is known about larger women's postnatal experiences. Overall my findings suggest that once the foetus had been safely delivered the women felt somewhat abandoned in that they were offered very little physical and emotional support in the postnatal period. By presenting monologues which demonstrate MHP framings of the 'good' and the 'bad mother' I have brought sharply into focus the ways that women are Othered in the context of MHC as demonstrated in stories which illuminate the tensions about taking responsibility for the weight of the body. In Chapter 9 I bring together some of the main findings and identify the contribution this research makes.

Chapter 9 Conclusion

In this chapter I discuss the main research findings and contribution the study has made. I also review the methodology used to answer the research questions, discussing the limitations of this approach and make suggestions for future research to extend the findings. I end the chapter with some reflection on the implications of the study in relation to ideas for public and professional engagement.

9.1 Contribution

This study draws on feminist epistemology and contrasting narratives which problematise the larger pregnant body, addressing a gap in what is known about larger women's experience of pregnant embodiment and MHC. The research makes a knowledge contribution about how MHC institutional discourse as well as medical practices shape larger women's experience of their bodies, pregnancies and childbirth, making larger women's experience more visible (Tischner & Malson, 2008). The research extends sociological understanding of the ways the context of MHC configures pregnant embodiment in the context of 'maternal obesity'.

The study aimed to investigate larger women's experiences of pregnancy and MHC and the context in which women experience their care by analysing the discursive framings participants drew on to represent and make sense of their experience. A variety of theoretical perspectives were utilised in conceptualising embodiment. Scheper-Hughes and Lock's (1987) and Jones' (2011) frameworks for thinking with the body helped with dealing with the difficulties with viewing the body as socially constructed, providing the means to study embodiment as lived, social, cultural and political.

The research illuminates the complexity of the interactions and practices larger women experience in the context of MHC, revealing how this context shapes pregnant embodiment. This is achieved by shifting the focus of inquiry from MHP problematisation of the larger pregnant body, to important questions about how MHP understand larger embodiment, and how this shapes their practice in relation to the care of larger women. These findings make a contribution to knowledge; potentially

helping to trouble some of the taken-for-granted practices which impact on larger women's experience of their pregnancies.

The research also makes a methodological contribution by adopting a novel narrative approach which extends Riessman's (2008) writing on dialogic performance analysis, adopting a hybrid structural approach to investigating and presenting how participants draw on a variety of discourses, adopting various positions in stories told during the course of research interviews. This approach reveals in detail how key MHP understand larger embodiment, and how these framings configure their practices with larger pregnant women.

The research findings are presented as a series of composite monologues which weave the women's and MHP findings together, revealing in detail how the context of MHC shapes larger women's experience of pregnant embodiment from early pregnancy through to the postnatal period. The monologues create a dialogue between the women, the MHP and the narratives drawn on to make sense of these experiences. This approach illuminates the ways that the highly visible nature of larger embodiment renders women (in)visible in medical spaces, due to the discursive framings drawn on by MHP which reduce women to the assumptions made about their lifestyles and body's capabilities. This is a highly novel approach to exploring how experience is configured by context, providing a means to juxtapose contrasting experience, revealing in detail the more invisible aspects of larger women's pregnant embodiment.

9.1.1 Early pregnancy

Important findings demonstrate that larger women's prenatal and early pregnancy experiences are far from straightforward, involving high levels of emotion work in relation to concerns about fertility. In early pregnancy my analysis revealed that previous worries about reproductive capabilities became concerns about pregnancy loss and 'what a pregnant body can do'. These worries may have been intensified by previous experience of the body as somewhat unpredictable. I found that the women's feelings of uncertainty also appeared to be heightened by a heavy burden of responsibility for the wellbeing of the foetus, leading to feelings of guilt, loneliness

and isolation. With women feeling uncertain about their body's capabilities, I also noted that they appeared to be somewhat reliant on biotechnologies in order to gain reassurance about foetal wellbeing. These findings support previous research exploring early pregnancy (e.g. Ross, 2015b, 2018). However, although women with 'low-risk' pregnancies may gradually develop confidence in their body's capacities in relation to pregnancy, I found that the concerns larger women had in early pregnancy were intensified by their interactions with MHC. With the current problematisation of the larger pregnant body these findings are important given that they draw attention to, not only the tentative and ambiguous nature of larger women's early pregnancy experiences, but also the ways that larger women's previous embodied experience shape engagement with biotechnologies.

In contrast to the women's experience, my analysis suggests that MHP had an agenda based on providing women with information about risk and lifestyle issues. Therefore, the highly visible nature of larger embodiment renders larger women the targets of unsolicited advice relating to lifestyles which MHP presume to be faulty. Furthermore, I found that the assumptions MHP made about the women's lifestyles presented the women with a range of difficulties associated with the provision of information about 'maternal obesity', not least of these being the provision of nutritional information based on the assumption that the women consumed too much sugar. I also found that MHP tended to frame women in relation to how responsible they assumed the women were for 'maternal obesity'. Moreover, these framings very much depended on whether the MHP positioned the women as in need of 'protection', or as 'deserving targets' of enhanced intervention. I suggest that MHP embodiment may play a part in this positioning, although this aspect of the research findings remains unclear, suggesting that further research is required to illuminate this important issue (I discuss this further in Section 9.3).

9.1.2 Mid and late pregnancy

In mid and late pregnancy, the findings demonstrate how interaction with the wider maternity team plays a key role in shaping the women's experience of pregnancy. In this respect, larger women may be subjected to a variety of practices relating to the dissemination of information to the wider community (who are believed to be

unknowingly infected with 'obesity') about the dangers of 'maternal obesity'. I noted that the women seemed somewhat invisible in this process, in which they are objectified in terms of how much of a barrier their adiposity presents to MHP access to the foetus. Furthermore, I suggest that the practice of providing information about the risks of maternal obesity also served to discipline women, transferring the blame for the difficulties MHP experienced in relation to larger embodiment from the MHP to the woman. I noted that this situation created difficulties for the women due to the burden of responsibility the women assumed for the foetus, and the level of criticism their embodiment attracts.

Although several studies have identified that MHP experience difficulties in assessing foetal growth and development in larger women (e.g. Singleton & Furber, 2014; Furness *et al.*, 2011; Schmied *et al.*, 2011), the current study is the first to demonstrate how the 'barrier of adiposity' figures in the relationships MHP have with larger women. My analysis illuminates how neoliberal discourses are drawn on by MHP, particularly when larger women's adiposity forms a barrier to seeing, hearing, feeling or reaching the foetus.

Relatedly, the current research illuminates a number of important findings in relation to how maternal obesity discourse and biomedical technologies act on larger women, serving as a means to responsibilise them, not only for their own embodied largeness, but also that of the foetal body. I found the highly visible nature of larger embodiment, coupled with policies which draw attention to the failings of the larger pregnant body, and expectations relating to foetal size, rendered larger women as highly visible targets for various MHC practices, including repeated targeted screening for GDM, and foetal growth monitoring. Furthermore, I found these practices were configured by anti-obesity discourse and expectations of large-for-gestational-age babies, creating maternal identities relating to 'good' and 'bad' mothers. An important finding related to this situation is that the foetal body also becomes stigmatised in this process.

The findings also suggest, in mid pregnancy, screening for GDM and foetal growth focuses attention further on women's eating in relation to foetal size. This places additional responsibility on women for the growth of the foetus. These important

findings illuminate how these practices configure women's experience of pregnancy and the expectations they have about foetal size, demonstrating how the politics of visibility (Tischner & Malson, 2008) function within MHC spaces where large bodies are highly visible but simultaneously silenced by the assumptions MHP make about larger women's lifestyles. Relatedly, Warin *et al.* (2012) have suggested that recent societal changes have brought about an intense interest in maternal consumption and infant adiposity. However, this is the first known study to demonstrate how women experience this aspect of their care. Furthermore, the implications of over medicalisation of pregnancy place women at significant risk of iatrogenic complications (DeJoy & Bittner, 2015; DeJoy, Bittner & Mandel, 2016). I would, therefore, suggest these findings merit further research, exploring how women experience foetal growth monitoring and how these experiences shape the decisions they make about their care.

9.1.3 Childbirth and the early postnatal period

The research findings in relation to childbirth made visible aspects of larger women's experience which would otherwise be rendered invisible due to the discrimination people with larger bodies face in healthcare spaces (Longhurst, 2005a). The findings demonstrate the larger pregnant body is problematised in terms of providing a barrier to the foetus during childbirth. Thus, whilst the women experience childbirth in terms of feeling exposed, and may struggle to contain and control their bodies, the MHP experience the childbirth process through the lens of risk, fearing the worst-case scenario. The findings also demonstrate how risk discourse is operationalised and acts on larger women, particularly in situations where MHP have difficulties accessing the foetus. Furthermore, midwives may seek to protect women from medical interventions which they think may unnecessarily lead to a 'cascade of intervention', criticising the label of maternal obesity in terms of over medicalising some larger women's pregnancies. These findings therefore suggest midwives may have an important role in helping larger women to achieve less medicalised birth. However, as previous research suggests that midwives experience a range of difficulties in relation to supporting women to have a less medicalised childbirth (Scamell, 2015), and the current research suggests that midwives may resist taking

more of the role in managing larger women's pregnancies, I would suggest further research is required. I will discuss this further in Section 9.3.

The findings suggest that in the early postnatal period women are rendered further (in)visible: feeling somewhat abandoned in the postnatal period. They may also be framed in unhelpful binary terms - as a 'good' or 'bad' mother, depending on their ability to mobilise after childbirth. The findings address a gap in what is known about larger women's experiences of the postnatal period. The research findings demonstrate how the good/bad framing of larger women as mothers brings sharply into focus the ways women are Othered by practices illuminating tensions about taking responsibility for the weight of the body during childbirth and in the postnatal period. These findings are significant in that postnatal experiences have attracted little research interest, and this is particularly so for larger women. I have therefore, been able to make a significant contribution to what is known about larger women's postnatal experiences.

9.2 Limitations of this research

The limitations of this research lie in both the ontological and epistemological approach I took. As I discussed in Section 3.2, knowledge claims made by constructionists are restricted in that meanings are created from within our social relations and practices (Berger & Luckmann, 1967). It follows, therefore, that although I have attempted to make more transparent my part in constructing the study data, I cannot claim the findings are objective. The findings reflect this methodological approach and those interpreting my findings must be aware of this aspect of my research design.

Following Mauthner and Doucet (1998), I have attempted to make more transparent my personal, professional and theoretical positionality in relation to the research, and given priority to the reflexive processes which I understand as helping to improve transparency in the research process. Mauthner and Doucet (1998: p.121) suggest that reflexivity:

> means reflecting upon and understanding our own personal, political and intellectual autobiographies as researchers and making

> explicit where we are located in relation to our research respondents. Reflexivity also means acknowledging the critical role we play in creating, interpreting and theorising research data.

By drawing attention to the issues identified in this quote I have signalled my acknowledgement of the limitations of research which is situated politically, historically and culturally (Smyth & Shacklock, 1998; Smythe & Murray, 2000).

I must also acknowledge that as I relied on data from narrative interviews as a sole form of data, a further limitation of this research relates to my methodological approach. Had I complemented the data drawn from the interviews with other methods it would have been possible to illuminate further both the context of MHC and the experiences of the women and MHP. Two methods come to mind with the potential to complement my approach. The first of these is solicited participant diaries and the second non-participant observations. Both of these methods can help to provide a form of triangulation and, while I am not so concerned with notions of 'truth' due to my ontological position, I understand that my findings could have been richer had I added in either or both of these methods. For example, solicited participant diaries would have helped to capture aspects of the women's on-going experience of embodiment and MHC between interviews and would have also allowed women to reflect on and capture their experience unencumbered by my presence. Non-participant observations in clinic spaces would also have helped to generate data about, not only verbal communication between women and MHP, but importantly would have helped to provide data about the interaction of bodies in clinical spaces.

I also acknowledge that critics of qualitative approaches would quite rightly draw attention to the limitations of the knowledge claims that can be made from small-scale studies, claiming the findings are less representative or notably generalisable to wider populations. However, I believe the findings of this study have potential in terms of being transferable to other contexts in that they help to sensitise others to experiences which may resonate with others in similar situations. Furthermore, bearing in mind that the discursive framings drawn on by the participants in the current study are likely to be recognisable to others outside the study site, some of

the experiences discussed in the context of this research may be recognisable to other people in different locations. Therefore, assuming due diligence, the current findings have relevance outside the context in which they were generated. Relatedly, the findings of this study would perhaps also benefit from a broader contextualisation in relation to women's experience of high-risk pregnancy. In this respect I suggest that further study exploring the experience of women with a variety of BMIs during pregnancy may help to generate further knowledge about the ways that risk discourse acts on the decisions women make during pregnancy. This point is developed further in the following section.

9.3 Future research

In the last section I pointed out that this research has limitations due to the design which focused on one setting. Future research could therefore involve applying the same design in different maternity settings. By doing so further knowledge can be generated in which to make comparisons over time and in relation to different settings and cultures. I suggest that by contrasting different contexts and approaches to managing larger women's pregnancies important knowledge would be gained about how these approaches configure larger women's embodiment and maternal identities. One way to do this would be to compare the experiences of women with a variety of BMIs and to also consider how social inequalities influence women's experience of pregnant embodiment and maternal healthcare.

Along with repeating the study in other contexts, I also suggest that some of the findings of the current study require a closer examination. An exemplification of this relates to my findings about how larger women are responsibilised for foetal growth and writing which draws attention to the way sugar has replaced fat as a serious threat to human health (Throsby, 2018). An area of potential future research would be to further study how notions of foetal permeability (Lupton, 2012a, 2013c), changing societal attitudes towards the 'big baby' (Keenan & Stapleton, 2010), reproductive citizenship (Warin *et al.*, 2012; Jarvie, 2016), and changing attitudes towards sugar consumption (Throsby, 2018) shape maternal identity.

Although my findings have much to say about larger women's experiences of embodiment and the ways medical regulation shapes these experiences. However, I suggest my work could, and should, be extended to explore further how some of the material aspects of MHC act on larger women's pregnant embodiment. In this respect I would like to draw attention to two aspects of my findings which I believe are particularly deserving of further investigation.

The first of these relates to findings which demonstrate the importance of specific objects which have significance in relation to maternal care. I would suggest future research could explore how various objects are used within healthcare interactions, investigating how these objects shape MHP practice and women's experience. Secondly, my findings have also revealed the significance of how larger bodies are handled (or not), and in this respect I would also suggest further study of ways MHP and larger women's bodies interact in the context of maternal caregiving. Such study would get closer to the material aspects of embodiment and regulation of the larger pregnant body.

In relation to objects in clinical spaces, I found biomedical technologies featured prominently in the narratives of both women and MHP, particularly in relation to the more contested aspects of the healthcare context. This is exemplified in Monologue 3: getting out the special pink leaflet (Section 6.4) and Monologue 5: getting out the big cuff (Section 6.6), where objects such as scales, BMI charts and 'special leaflets' played a particular role in disciplining larger women in the context of antenatal care. A potential extension of the current study would be to further examine how objects figure in the interactions between MHP and larger women in clinical contexts. An approach such as this could be theoretically informed by social anthropological writing on cultural materiality which brings together, for example, ethnomethodological approaches with discursive approaches (e.g. Geismar & Horst, 2004; Nevile *et al.*, 2014). Cultural materialist approaches are particularly useful for analysing how people "interact with objects, and use objects to interact with others" in sociocultural contexts (Nevile *et al.*, 2014: p.4). A further worthwhile extension to the approaches described by Nevile *et al.* (2014) would be to combine the structural narrative approach which I have described with ethnographic methodology,

examining in detail where discursive and embodied actions are analysed in the context in which they arise.

My findings relating to embodiment in clinical spaces also suggest the boundaries between MHP and women's bodies are an aspect of MHC where women experience the reluctance of MHP to physically and emotionally support them. Examples of such situations occurred in monologues where women are expected to support and mobilise their bodies independently, such as Monologue 20: walking those legs off (Section 8.5), and also Nicola, Anna and Susie's stories about mobilising after epidural and spinal anaesthesia (Section 8.7). I would suggest these aspects of women's care require further study, exploring the ways MHP and women's bodies are experienced individually, and in relation to each other (and to objects) in clinical spaces. An important aspect of further study would be to explore further the boundaries between bodies in medical spaces, engaging with dialogue, body language, objects and embodiment in the context they occur. Research drawing on ethnographic methods and writing from the field of cultural materiality would provide a means to explore in more detail how "language and embodied conduct" produces particular kinds of bodies and achieves particular ends (Nevile *et al.*, 2014: p.5). A worthwhile angle potentially would be exploring moving and handling larger bodies as a form of 'dirty work', perhaps exploring how distance is maintained from bodies which are deemed impure (e.g. Douglas, 1966; Artner & Atzl, 2006).

I have made some suggestions for future research which could generate further knowledge by extending the research design to incorporate further the physical world. I would also like to suggest a more 'radical' ontological shift might help to theorise further about the women's experience of pregnant embodiment. I situated my work within the 'linguistic turn' and acknowledge that essentially this theoretical positionality has a focus on how the social world *is constructed*. Had I considered what has been described as the 'turn to matter' (new materialism) (Fox & Alldred, 2018) I would have been better able to generate knowledge about the *social production* of the larger pregnant body. New materialists consider that the social world is produced by various material influences which include social, cultural, psychological and biological (Barad, 1996; Braidotti, 2013). According to Fox and

Allred (2018: p.2) these approaches help to "cross[es] boundaries between natural and social worlds". In considering the experiences of the pregnant women both prior to and particularly during early pregnancy had I drawn on some of the ideas from new materialism I would have been able to consider 'fat embodiment' in a manner which de-stabilised the notion of human agency (Deleuze & Guattari, 1988) helping me to theorise further about how the larger pregnant body is produced. I suggest that had I drawn on some of the ideas from new materialism I could have explored further the ways that women experience embodied desire, control and the 'unpredictable' cravings of early pregnancy.

9.4 Implications for care improvement

In the broadest terms, the findings of this research suggest a number of MHC practices negatively shape larger women's experience of pregnancy. Therefore, I would like to draw attention to some of the areas which have implications for practice, potentially making improvements to larger women's experiences of pregnant embodiment and MHC.

Overall, my findings indicate larger women need to become more visible, as individuals, as a starting point for improving their experiences of pregnancy and MHC. More specifically, early pregnancy may be particularly difficult for women who feel a high level of concern about their body's reproductive capabilities, responsibility towards the foetus and a fear of being negatively judged by MHP. My findings highlight how larger women may suffer in silence due to lack of opportunity to talk to MHP about their concerns. I suggest that, on this basis, women may need opportunities to explore their concerns with MHP who are prepared to suspend judgment in relation to larger women's lifestyles. Additionally, rather than seeking to provide women with standard information about lifestyle issues, MHP could focus on getting to know women better, learning about women's needs and wants.

Women also need information about pregnant embodiment which addresses the issues that concern them. The women in the current study reported a lack of non-discriminatory information about how to deal with a larger body during pregnancy. This was particularly so in relation to consistent, evidence based and unbiased

information about GWG. Furthermore, women indicated that they require more information about the larger body in pregnancy and labour, addressing their information needs about how to understand and help their bodies perform better.

The postnatal period was also identified as problematic for the women, who raised the issue of feeling abandoned after childbirth. This situation was particularly demanding given they were dealing with the physical effects of medical interventions and a newborn infant. The findings also point towards the struggle women had in the postnatal period, indicating that they felt they were 'bad mothers', and these findings have been documented elsewhere (Healy, 2012). Although MHP may believe that larger women are unaware of their adiposity, my findings suggest that this is not the case. Indeed, women may be highly sensitive to negative judgements which increase the levels of guilt they feel about their embodiment. Larger women may therefore need more emotional support than they currently receive following childbirth to help them feel stronger in their maternal identities.

In conducting this research, an aim was to shift the discussion from: what do MHP say is problematic about the larger pregnant body? To: how does the way MHP understand larger embodiment shape their practice in relation to the care of larger women? I believe I most certainly achieved this aim. The findings suggest there is a need for MHP to reflect on their understanding of larger embodiment, and to generate a deeper understanding of their practices in relation to the larger body. Although previous research has identified various educational needs of midwives, these tend to be focussed on dealing with weight-related issues in pregnancy (e.g. Singleton & Furber, 2014). I suggest that rather than educating midwives about how to raise issues of weight with larger women, what is likely to be more helpful is professional engagement to help sensitise midwives to the issues which women identify as being critically important (i.e. information about the larger body in pregnancy).

Part of my thinking behind the production of the monologues in this thesis was that I hoped they would illuminate how specific practices acted on Other. At the time of writing the monologues I was aware of how powerful they were in this respect and could see their potential in relation to raising awareness about the issues which

participants identified as problematic. On this basis, I suggest the monologues have engagement potential, providing the means to begin a dialogue using drama to further explore the issues raised by the current research. Live drama has been used successfully for this purpose in Nova Scotia, helping a variety of health professionals think about weight-related issues from different perspectives, reducing weight stigma (e.g. Kirk, Price & Sim, 2013).

One of the most problematic issues the current research raised was the notion of how risk discourse was utilised as a means to discipline larger women. As I have discussed, the findings suggest MHP experienced risk as an everyday aspect of their work, and this was a particularly problematic aspect of practice for some MHP. Having found the communication of risk to be bound up in the regulation of larger women's bodies, I would suggest further research and professional/public engagement work is required to shed further light on this important aspect of care. One way of doing this would be to bring women and MHP together to think about how notions of risk act on pregnancy. For example, MHP could work with women to produce information specifically for larger women about how larger bodies perform in pregnancy, addressing the issues which concern women the most. This would help to deal with some of the issues I have identified in this research about the lack of counter-narratives to help women make decisions about their care.

The research findings also seem to point towards how some midwives would like to be more involved in larger women's care. Therefore, if more midwives could be encouraged to take a leadership role in relation to the care of larger women with less complex pregnancies, perhaps more women could benefit from the midwifery model of care which has been shown to have positive benefits for pregnancy outcomes (e.g. van Teijlingen, 2005; Healy, Humphreys & Kennedy, 2016a). I suggest this would not be possible unless midwives have the opportunity to explore the issues raised by the current research.

Previous research conducted in the UK has identified that midwives make a range of assumptions about larger women (e.g. Heslehurst *et al.*, 2013). Therefore, these findings support those of the current research in a range of ways. I suggest that improving larger women's MHC experiences would require further midwifery

engagement and education, involving helping midwives explore how they view the larger pregnant body, and also to reflect on how they view their role in supporting women to understand larger embodiment in the context of pregnancy and childbirth.

The ways that risk acts in maternity contexts is a particularly thorny subject representing a complex and long running conversation (e.g. Lane, 2008; Healy, Humphreys & Kennedy, 2016a). However, the current research has demonstrated that the position larger women occupy in the context of MHC may make them 'unpopular patients' (Stockwell, 1972), and therefore, strong midwifery leadership would be required to help make such changes. Further research would also be required to investigate how increased involvement of midwives might improve women's experience of pregnancy, MHC and pregnancy outcomes.

9.5 To end

I began this thesis with an excerpt from the field notes I made following the first interview of the study with Anna. What I wrote captured the awkwardness I felt about my own embodiment, and my concerns about how Anna might view the research and me as a researcher. The excerpt also demonstrated my growing awareness of how anti-obesity discourses act in social contexts. I would like to end this thesis with a quote from Erin Morgenstern's book *The Night Circus*. The quote says something about how stories act on human beings.

> You may tell a tale that takes up residence in someone's soul, becomes their blood and self and purpose. That tale will move them and drive them and who knows what they might do because of it, because of your words. That is your role, your gift.
>
> (Morgenstern, 2011: p.82)

I hope the stories I have generated with the research participants provoke meaningful change and I offer them as a gift to you.

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Appendices

Appendix 1: The Research Advisory Group (RAG)

I recruited both professional and lay members to the RAG; however, although I found it relatively easy to recruit professional members, it was challenging to recruit larger women. The difficulties I experienced alerted me to the potential difficulties I might have in recruiting participants to the study.

Professional RAG members were recruited through: handing out leaflets and talking to people at a small midwifery conference, distributing leaflets to established health visiting contacts; local breast-feeding support co-ordinators; and via leaflet distribution within the HAYES® UK organisation. I aimed to recruit lay members from groups where women had already self-identified as having a larger body in the hopes that they would feel more confident in coming forward, e.g. I tried to recruit from the HAES® organisation via the on-line discussion forum. I also contacted health visitors and local weight-loss groups. Despite casting a fairly wide net in terms of the recruitment of lay members, very few women came forward.

Ultimately, although RAG members included both lay and professional members, there was also some overlap in that one of the lay members was a health professional, and some of the professional members self-identified as larger women who had experienced pregnancy and childbirth. Although I did not plan to recruit only female professional members no male professionals came forward. Lay members were women who self-identified as having a BMI which placed them in a 'high-risk' category during pregnancy. All the advisory group members were from across Scotland and not necessarily from within the research site.

Lay members

Jenny[61], a 32-year-old woman who was expecting her third baby, and was in the last few days of her pregnancy. Although, she was due to be admitted to her local maternity hospital for a planned caesarean section, she generously shared her thoughts and experiences of maternal healthcare, childbirth and pregnancy during a long telephone conversation.

Linda, a 26 year-old-woman with one child, who again, shared her thoughts and experiences during a fairly lengthy email exchange. Linda also reviewed the language used in the

[61] None of the names used in this section are the real names of the RAG.

participant recruitment documentation and the research interview topic guides. This feedback was particularly helpful as it alerted me to the ways that some of the vocabulary from the literature I had been reading had leaked into the language used in the topic guides. I had framed my topic guides around experiences of 'living with a larger body' and this advisory group member alerted me to the ways that she perceived this language. Linda's comments helped me to reflect further on mind/body duality, a theme that runs through my reflection on the theoretical underpinnings of my work.

Professional members

The professional group members included: a NHS Health Promotion Specialist involved with a health improvement initiative with 'larger' women; a NHS Antenatal Health Education Co-ordinator (midwife); a Midwife; a Consultant Midwife (also the NHS gatekeeper for the study); a Professor of Maternal Health; a Consultant Obstetrician.

The contributions of the professional advisory group members fell into three main areas: sensitising me to cultural issues and language-in-use; provision of information relating to accessing the research site and the recruitment of pregnant women; reviewing recruitment materials and topic guides.

Most of the discussions took place via individual email or telephone calls. The exception to this being the consultant obstetrician who kindly agreed to review the obstetrician's interview topic guide and meet afterwards in person to discuss it

All the professional members of the group contributed to the project by reviewing the materials used in the recruitment of midwives, obstetricians and anaesthetists to the study. This was a particularly important role of the RAG as it ensured that the recruitment materials were more likely to be well received by potential participants. Through my discussions with the professional group members I was sensitised to the language they used to talk about the body, and body size and weight, I noted that the practicing midwives commonly used the term 'raised BMI'. I understood that it was important to be specific about inclusion criteria for the study with regards to weight, and it appeared that this term was favoured, as it was perceived as a neutral term. As the health care professionals were comfortable with this term I selected 'BMI' as a way of 'categorising' women by their weight and used BMI on the participant information materials for the professionals. However, I also noted that it was a medical term, which lay people may be unfamiliar with, and therefore, it was used with care in relation to the recruitment of the pregnant women. I was also conscious that if I selected a

medical term the participants were likely to perceive the study as biomedical when I was actually interested in their experiences.

Some of the professional members also reviewed the women's interview guides and advised on areas which they felt were important from their professional experience. I used this information to supplement (or unsettle) the knowledge gained from the literature review and adjusted the wording of the topic guides accordingly.

The obstetrician and midwives advised on matters relating to accessing the research site. This information was invaluable and helped me to understand how both professionals and pregnant women might perceive my research, and I was therefore able to identify an approach to accessing the research site which would be acceptable to the practitioners who worked there.

Discussions with the midwives in the group were particularly helpful in formulating the recruitment strategy for the pregnant women; for example, I was able to rule out asking community midwives to help with the recruitment of women as this had been previously identified as problematic due to the workload commitments of these midwives.

Appendix 2: Project flowchart

Project flowchart

Step 1: Identification of eligible participants meeting inclusion criteria

Pregnant woman who:

1. Has a BMI of ≥ 35 recorded on hand-held maternity records at booking appointment.
2. Will receive maternity care at **** Hospital.
3. Has no other risk factor(s) likely to complicate the pregnancy or birth e.g. essential hypertension, diabetes, previous pregnancy loss etc.
4. Is over 16 years of age.
5. Is experiencing her first pregnancy.
6. Speaks and is able to understand written English.
7. Has had an ultrasound scan at 11-14 weeks gestation showing a singleton pregnancy with no abnormalities.

Midwives who:

1. Provide care to women in ****.

Obstetricians who:

1. Provide care to women in ****.

Step 2: Recruitment of participants (a minimum of 15 women, 6-8 midwives and 3-4 obstetricians)

1. **Promotion of the research project** – Posters and leaflets will be used to promote the project within the antenatal clinic at **** Hospital. The researcher will also meet with community midwives, obstetric, administrative, and ultrasound staff to discuss the project and answer questions (organised through the NHS gatekeeper (****).
2. **Recruitment of maternity service users** – Organised through the NHS gatekeeper ****. Following the booking appointment with the local midwife at ≤ 12 weeks gestation a booking referral form is sent to **** Hospital Records Department so that administrative staff can organise routine ultrasound

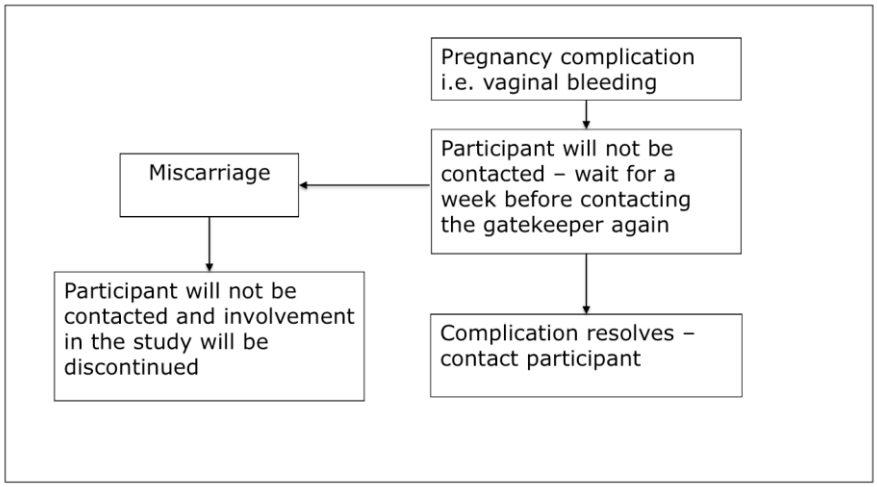
appointments for women. Women who meet Inclusion Criteria 1-6 will be posted an Invitation Letter (Appendix *) and Participant Information Sheet (Appendix *) by the administrator. The invitation letter seeks permission from women to be approached by the researcher to discuss the study when they attend an appointment for a routine ultrasound scan at 11-14 weeks gestation. For those women who have opted-in to be approached (by reply slip or other means of contact), the researcher be in attendance at the scan department, only women with scans indicating a singleton pregnancy with no abnormalities will be approached (Inclusion Criteria 7, see 'Step 1' of this protocol). The sonographer will be asked, in these circumstances, to introduce the potential participant to the researcher.

3. **Recruitment of midwives and obstetricians** – Organised through the NHS gatekeeper ****. An Invitation Letter (Appendix *) and a Participant Information Sheet (Appendix *) will be emailed to the NHS email account of all midwives and obstetricians who meet the study criteria. Those invited will be asked to respond to the email indicating their area of practice and length of service so that a sample may be selected from these potential participants. These responses will be followed up, providing further information where necessary.

Step 3: Informed consent and data collection – Interview one - Women 15-17 weeks gestation

1. **Pre-interview** - Prior to contacting the participant, the researcher will check with the NHS gatekeeper that all is well with the participant's pregnancy.

The following flow chart will be used to inform decision making should pregnancy complications occur:



2. **Arrangement of interview** - using participant's preferred method of contact and choice of location - potential venues include the participant's own home, NHS clinic or the university. The interview venue will be selected to ensure privacy.
3. **Review of participant information sheet with participant and informed consent** - Participant information Sheet (Appendix *) and Consent Form (See Appendix *).
4. **Interview as per interview schedule and topic guide** - audio-recorded semi-structured interview lasting approximately an hour will be carried out with the participant according to the Interview Schedule and Topic Guide (See Appendix *).
5. **Post-interview information given to participants** – Post-interview Information Sheet (See Appendix *).

Step 4: Informed consent and data collection – Interview – Midwives and obstetricians (concurrent with the above)

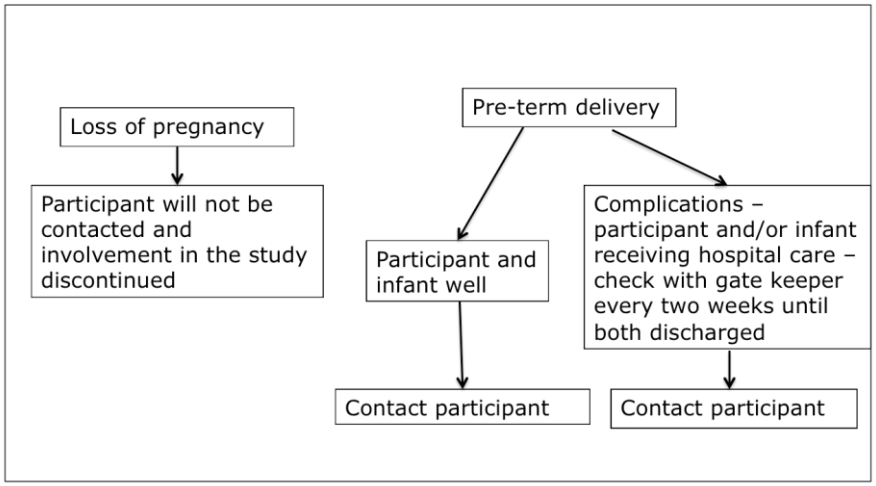
1. **Arrangement of interview** - using participant's preferred method of contact and choice of location - potential venues include the participant's own home, NHS clinic or the university. The interview venue will be selected to ensure privacy.

2. **Review of participant information sheet with participant and informed consent** - Participant information Sheet (Appendix *) and Consent Form (See Appendix *).
3. **Interview as per interview schedule and topic guide** - audio-recorded semi-structured interview lasting approximately an hour will be carried out with the participant according to the Interview Schedule and Topic Guide (See Appendix *).
4. **Post-interview information given to participants** – Midwife Post-interview Information Sheet (See Appendix *)/Obstetrician Post-Interview Information Sheet (See Appendix *).

Step 5: Data collection and informed consent – Interview Two - Women 32-34 weeks gestation

1. **Pre-interview** - Prior to contacting the participant, the researcher will check with the NHS gatekeeper that all is well with the participant's pregnancy.

The following flow chart will be used to inform decision making should pregnancy complications occur:



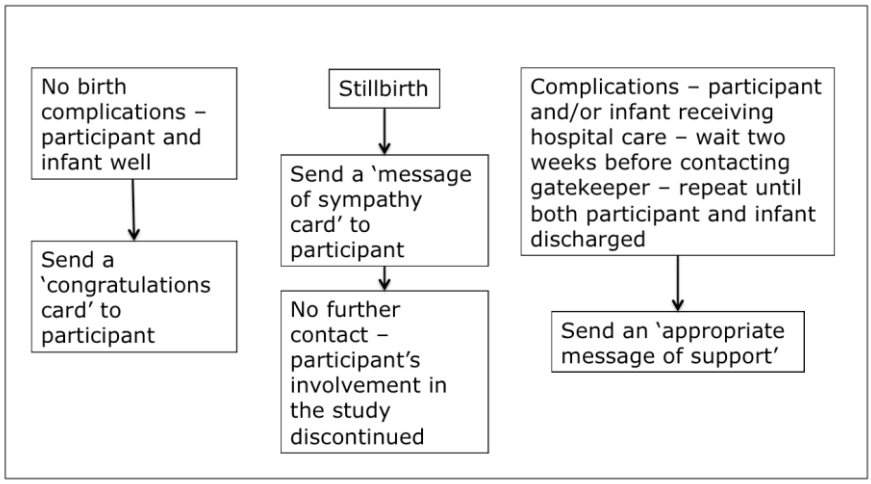
2. **Arrangement of interview** - using participant's preferred method of contact and choice of location - potential venues include the participant's own home, NHS clinic or the university. The interview venue will be selected to ensure privacy.
3. **Review of participant information sheet with participant and informed consent** - Participant information Sheet (Appendix 5) and Consent Form (See Appendix *).

4. **Interview as per interview schedule and topic guide** - audio-recorded semi-structured interview lasting approximately an hour will be carried out with the participant according to the Interview Schedule and Topic Guide (See Appendix *).
5. **Post-interview information given to participants** – Post-interview Information Sheet (See Appendix *).

Step 6: Congratulating the participants on the arrival of their babies

2. Following the expected date of delivery for each woman, the researcher will ask the NHS gatekeeper to check that there are no reasons not to send a card to the participant.

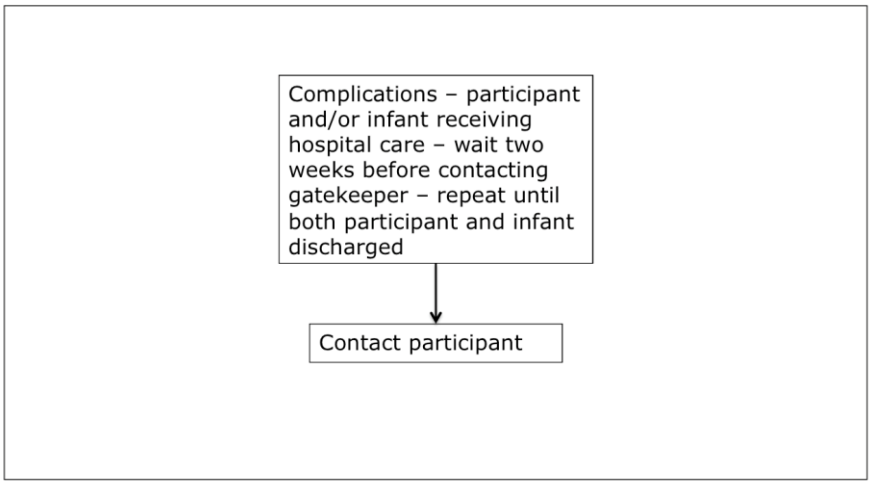
The following flow chart will be used to inform decision making should birth complications occur:



Step 7: Informed consent and data collection – Interview Three - Women two-four months postpartum

1. **Pre-interview** - Prior to contacting the participant, the researcher will check with the NHS gatekeeper that all is well with the participant and her baby.

The following flow chart will be used to inform decision making should complications occur:



2. **Arrangement of interview** - using participant's preferred method of contact and choice of location - potential venues include the participant's own home, NHS clinic or the university. The interview venue will be selected to ensure privacy.
3. **Review of participant information sheet with participant and informed consent** - Participant information Sheet (Appendix *) and Consent Form (See Appendix *).
4. **Interview as per interview schedule and topic guide** - audio-recorded semi-structured interview lasting approximately an hour will be carried out with the participant according to the Interview Schedule and Topic Guide (See Appendix *).
5. **Post-interview information given to participants** – Post-interview Information Sheet (See Appendix *) and Final Post-interview Information Sheet (See Appendix *).
6. **Ending the research relationship** - interviewer will give each participant a card to thank them for their participation in the study and provide the participant with the opportunity to reflect on their participation and say goodbye.

Information about the research

Exploring experiences of pregnancy and childbirth with women of above average weight, midwives and obstetricians

An invitation to participate

We would like to invite you to participate in this research project. Before you decide whether you would like to take part, please read the information about the project and feel free to ask questions about anything that you are not sure about.

What is the study about?

The study explores the experiences of women who are pregnant with their first baby and who are above average body weight. The main aim is to use this knowledge to develop improved support and services to pregnant women in the future.

Why have I been invited to take part?

You have been invited to take part because you are receiving maternity care in [locality] and are expecting your first baby. This invite has come via [locality] NHS maternity services – your information has **not** been passed onto the research team. The research will involve gathering the experiences, views and opinions of a minimum of 15 maternity service users, eight midwives and two obstetricians.

Do I have to take part?

No, it's up to you to decide whether or not to join the study. Your decision will not affect the standard of care you receive. Time will be taken to discuss with you what taking part in the study involves. You will also be given an opportunity to ask any questions that you have. Please take time to decide whether you want to be involved in the study and discuss your decision with others if you wish. If you do decide to take part in the research you will be asked to sign a consent form.

What will happen to me if I take part?

Over the course of your pregnancy, and in the period after the birth, you will be asked to take part in three audio-recorded interviews lasting for about an hour. The first will take place around 15 weeks, the second around 32 weeks and the last one between two and four months after your baby is born. The interviews will take place at a location convenient for you. During the interviews you will have the opportunity to share your experiences of pregnancy, birth, being a new mother and the interactions you have with health care professionals and other people.

Will my taking part in the study be kept confidential?

Identifying information that you give to the researcher i.e. name, address or phone numbers will be kept securely and separately from your interview recordings and transcripts (the research data). The information that you give to the researcher will be kept confidential; exceptions to this include disclosures of harm to self or others. Access to research data will be restricted to members of the research team and regulatory authorities. Your real name will not be used within the study report. All recordings, electronic and written data will be kept securely in locked cabinets and computers that are password protected. The research data will be stored securely and then be destroyed within five years of the completion of the study.

What happens if I change my mind about taking part in the study?

You can change your mind about taking part in the study at any time without giving a reason. Any data that you have contributed to the study will still be included in the study unless you ask for it to be removed.

What are the possible advantages and disadvantages of taking part?

Taking part in the study will not necessarily benefit you directly, but your contribution will help in gaining a better understanding of the issues affecting pregnant women of above average weight. This knowledge will be used to assist in the development of better services and support in the future.

It is not expected that taking part in this study will cause you any emotional discomfort.

What will happen to the findings of the study?

The findings of the study will contribute to an academic qualification that will be submitted to [university]. They will also be shared with health care professionals and other interested parties by publications in academic journals, professional seminars and training events.

Who is funding this study?

The study is funded by [university].

Who has reviewed this study?

Permission to carry out this study has been given by the [locality] Research Ethics Committee.

What if I am unhappy about any aspect of taking part in this study?

Everything will be done to make sure that you are not inconvenienced and that we have protected your rights but, if you are concerned or unhappy about any aspects of the study, please contact [supervisor] who is the project principle academic supervisor at [university].

Where can I get further information or volunteer to take part in the study?

If you would like to find out more about this study, or volunteer to take part, please send your name and contact details to **Sue Chowdhry**.

By text: [mobile number]

By email: s.chowdhry@[address]ac.uk

Phone: [number]

By letter: FREEPOST [number] ATTN: Sue Chowdhry, [address].

Thank you for taking the time to read this information.

Please do not hesitate to contact us if you require further information.

Women's Participant Information Sheet Version 1 10/07/13

Information about the research

Exploring experiences of pregnancy and childbirth with women of above average weight, midwives and obstetricians

An invitation to participate

We are seeking midwives and obstetricians who provide maternity care within [locality] to participate in a qualitative research project. Before you decide whether you would like to take part, please read the information about the project and feel free to ask questions about anything that you are not sure

What is the purpose of the study?

This study will add to the small body of knowledge exploring how pregnant women with a BMI of ≥ 35 experience pregnancy, the changing pregnant body and maternity care. The main aim is to use this knowledge to develop a better understanding of the issues affecting the experience of maternity care and to use this knowledge to inform the development of improved support and services to women in the future.

Why have I been invited to take part?

Your experience as a health care professional with responsibility for the maternity care of women with a BMI of ≥ 35 is invaluable. Sharing your experiences and thoughts will help provide the multiple perspectives that are required to gain insight into the complex factors affecting the care of this group of maternity service users. I aim to recruit at least 15 maternity service users, eight midwives and two obstetricians to share their experiences, views and opinions.

Do I have to take part?

No, participation in this study is voluntary. Time will be taken to discuss with you what taking part in the study involves. You will also be given an opportunity to ask any questions that you have. Please take time to decide whether you want to be involved in the study and discuss your decision with others if you wish. If

you do decide to take part in the research you will be asked to sign a consent form.

What does taking part in the study involve?

You will be asked to participate in an audio-recorded individual interview with the researcher about your experiences, views and opinions of caring for women with a BMI of ≥ 35. The interview will be conducted in a private location of your choosing. The interview will last for approximately an hour and will be organised according to your convenience.

Will my taking part in the study be kept confidential?

Identifying information that you give to the researcher i.e. name, address or phone numbers will be kept securely and separately from your interview recordings and transcripts (the research data). The information that you give to the researcher will be kept confidential; exceptions to this include disclosures of harm to self or others. Access to research data will be restricted to members of the research team, research and regulatory authorities. Your real name will not be used within the study report. All recordings, electronic and written data will be kept securely in locked cabinets and computers that are password protected. The research data will be stored securely and then be destroyed within ten years of the completion of the study.

What happens if I change my mind about taking part in the study?

You can change your mind about taking part in the study at any time without giving a reason. Any data that you have contributed to the study will still be included in the study unless you ask for it to be removed.

What are the possible advantages and disadvantages of taking part?

Taking part in the study will not necessarily benefit you directly, but your contribution will help in gaining a better understanding of how midwives and obstetricians feel about caring for women who have higher BMIs. This knowledge will be used to assist in the development of better services and support in the future.

It is not expected that taking part in this study will cause you any emotional discomfort.

What will happen to the findings of the study?

The findings of the study will contribute to an academic qualification that will be submitted to [university]. They will also be shared with health care professionals and other interested parties by publications in academic journals, professional seminars and training events.

Who is funding this study?

The study is funded by [university].

Who has reviewed this study?

Permission to carry out this study has been given by the [locality] Research Ethics Committee.

What if I am unhappy about any aspect of taking part in this study?

Everything will be done to make sure that you are not inconvenienced and that we have protected your rights but, if you are concerned or unhappy about any aspects of the study, please contact [supervisor] ☏ [number] 🖰 [email] who is the project principle academic supervisor at [university].

Where can I get further information or volunteer to take part in the study?

If you would like to find out more about this study, or volunteer to take part, please send your name and contact details to **Sue Chowdhry**.

By text: [number]

By email: s.chowdhry@[address].ac.uk

Phone: *[number]

By letter: FREEPOST [number] ATTN: Sue Chowdhry, [address].

Thank you for taking the time to read this information.

Please do not hesitate to contact us if you require further information.

Appendix 5: Women's consent form

Consent Form

Participant identification: _____

Title of Project: Exploring experiences of pregnancy and childbirth with women of above average weight, midwives and obstetricians

Name of Researcher: Sue Chowdhry

Please initial all boxes

1. I confirm that I have read and understand the information sheet dated 10/07/13 (version 1) for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily. ☐
2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason. ☐
3. I understand that individuals from within the research team and regulatory authorities may look at data collected during the study. I give permission for these individuals to have access to this data. ☐
4. I give permission for the interview to be audio-recorded and transcribed. ☐
5. I agree to statements that I make during the interview being used anonymously in the presentation of the research. ☐
6. I agree to take part in the above study. ☐

_____ _____ _____

Name of participant Date Signature

_____ _____ _____

Name of person taking consent Date Signature

Appendix 6: Professionals' consent form

Consent Form

Participant identification: _____

Title of Project: Exploring experiences of pregnancy and childbirth with women of above average weight, midwives and obstetricians

Name of Researcher: Sue Chowdhry

Please initial all boxes

7. I confirm that I have read and understand the information sheet dated 10/07/13 (version 1) for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily. ☐
8. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason. ☐
9. I understand that, individuals from within the research team and regulatory authorities may look at data collected during the study. I give permission for these individuals to have access to this data. ☐
10. I give permission for the interview to be audio-recorded and transcribed. ☐
11. I agree to statements that I make during the interview being used anonymously in the presentation of the research. ☐
12. I agree to take part in the above study. ☐

_____	_____	_____
Name of participant	Date	Signature

_____	_____	_____
Name of person taking consent	Date	Signature

Appendix 7: Women's invitation letter

Dear

I am writing to ask you to consider taking part in an important research project taking place within [city]. The aim of the project is to explore experiences of pregnancy and childbirth with women of above average weight. The findings of the study will be used to improve the support and services that are available to pregnant women in NHS [locality].

I have enclosed information about the research project detailing what taking part involves. Please feel free to contact the researcher, Sue Chowdhry if you require any further information.

Sue will be in the department when you attend for your ultrasound scan and would like to talk to you about the research and give you the chance to ask any questions. If you give your permission for her to do this please complete the form over the page. Alternatively, if you would like to find out more about the study, or would like to volunteer to participate, please contact her directly.

This letter has been given to you by NHS Maternity Services; your information has not been passed on to the research team.

Thank you for taking the time to read this letter.

Yours Sincerely,

[NHS Maternity Services Gatekeeper]

Appendix 8: Study poster

Are you expecting your first baby?

Could you help?

We are keen to know more about how pregnant women with above average weight experience pregnancy, childbirth and early motherhood and about how they feel about the maternity care that they receive

If you are expecting your first baby and have a Body Mass Index[1] (BMI) of 35 and over we would like to invite you to take part in our study

Learning more about the feelings and experiences that women with higher BMIs will help us to develop the types of support and services that women say that they want

If you would like to find out more about this research please ask the clinic staff to give you a leaflet

[1]BMI is calculated by dividing weight by height[2] and is used to calculate whether a person is underweight, average weight, or overweight for their height.

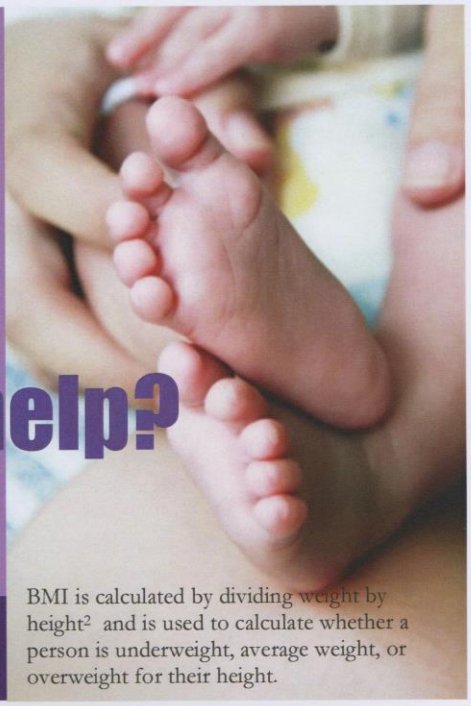
Version 1 - 10/07/2013

Appendix 9: Study leaflet

Are you expecting your first baby?

Could you help?

Is your BMI over 35?



BMI is calculated by dividing weight by height[2] and is used to calculate whether a person is underweight, average weight, or overweight for their height.

We are keen to know more about how pregnant women with above average weight experience pregnancy, childbirth and early motherhood and about how they feel about the maternity care that they receive.

If you are expecting your first baby and have a Body Mass Index[1] (BMI) of 35 and over we would like to invite you to take part in our study.

Learning more about the feelings and experiences that women with higher BMIs will help us to develop the types of support and services that women say that they want.

If you would like to find out more about this research project please contact:

Sue Chowdhry

Appendix 10: MHP invite letter

Dear Midwife/Obstetrician,

I would like to ask you to consider taking part in a research project taking place within [location]. The aim of the project is to explore experiences of pregnancy and childbirth with women of above average weight. I would like to interview midwives and obstetricians who work in [location] and have experience of caring for women with body mass indexes of ≥ 35. Full details about the study are included in the information sheet attached to this email.

If would like to volunteer to participate in the study, or require further information, please reply to this email with your contact details.

Thank you for taking the time to read this letter.

Yours Sincerely,

Sue Chowdhry

Exploring experiences of pregnancy and childbirth with women of above average weight, midwives and obstetricians
Interview Schedule and Topic Guide
Interview One – women 15-17 weeks gestation

Pre-interview:

- Review the *Participant Information Sheet* with the participant and answer any questions about the nature and purpose of the study and the format of the interview including: breaks/stopping at any time/finish another day/length interview 1 hour approximately/no right or wrong answers/assure answers will not affect care in anyway.
- Discuss confidentiality/limits of confidentiality/advise re disclosure and child protection policy.
- Advise participant that they do not have to disclose any information if they feel uncomfortable doing so.
- Advise participant of their right to withdraw from the study at any point without giving reason/right to withdraw all or part of their interview data.
- Ask participant to review and sign the consent form. Ensure participant has a copy of the *Participant Information Sheet* and the signed *Consent Form*.
- Ask participant to choose a name that they will be referred to within the study.
- Direct any clinical issues to relevant clinical staff.

Interview:
Collect demographic information
The aim of this interview is to explore

- How participants feel about being pregnant
- How they perceive others feel about their pregnancy
- Feelings towards their pregnant body
- Self-care and health care including perceptions of health care relationships

Beginning the Story of Pregnancy – Topic guide:
This first section of the interview is about your feelings about finding out you were pregnant and about early pregnancy.
Finding out about the pregnancy

- Feelings about becoming pregnant

Telling others

- Experience of telling others about the pregnancy
- Perceptions of others reactions to the pregnancy

Early experiences of pregnancy

- Bodily experience of being pregnant

- Fears/worries/pleasures

Health and wellbeing

There is a lot of information and advice given to pregnant women about looking after their health and wellbeing when they are pregnant. The next section of the interview is about your views on looking after your health and wellbeing in pregnancy and health information.

- Preparation for pregnancy (if any)
- Feelings about health/wellbeing
- Concerns about weight related issues
- Sources of information
- Changes in self-care practices
- Facilitators/barriers to health and wellbeing maintenance

Experiencing health care

This last section is about the maternity care that you've had so far.

- Contact with health care staff
- Perceptions of relationships with health care staff
- Perceptions of judgements/expectations of staff
- Appointments that stand out

Ending the interview

- Any further thoughts

Post-interview:

- Debriefing session - immediate feelings or questions discussed. Give participant the *Post-interview Information Sheet*.
- Give opportunity for participant to ask any further questions about the study.
- Thank participant for their time and reassure her about confidentiality and anonymity.
- Brief about next steps – check participants preferred means of contact to arrange next interview – check participant has contact information for the study team.

Appendix 12: Interview 2 topic guide, women

Exploring experiences of pregnancy and childbirth with women of above average weight, midwives and obstetricians
Interview Schedule and Topic Guide
Interview Two – Women 32-34 weeks gestation

Pre-interview:

- Review the *Participant Information Sheet* with the participant and answer any questions about the nature and purpose of the study and the format of the interview including: breaks/stopping at any time/finish another day/length interview 1 hour approximately/no right or wrong answers/assure answers will not affect care in anyway.
- Discuss confidentiality/limits of confidentiality/advise re disclosure and child protection policy.
- Advise participant that they do not have to disclose any information if they feel uncomfortable doing so.
- Advise participant of their right to withdraw from the study at any point without giving reason/right to withdraw all or part of their interview data.
- Ask participant to review and sign the consent form. Ensure participant has a copy of the *Participant Information Sheet* and the signed *Consent Form*.
- Direct any clinical issues to relevant clinical staff.

Interview:

The aim of this interview is to explore

- The perceptions and feelings that participants have towards their body as their pregnancy progresses
- The ways that the participants care for themselves during pregnancy
- Perceptions of antenatal health care and health care relationships
- Important sources of information relevant to self-care
- Attitude towards impending childbirth and motherhood

Continuing the story of pregnancy – Topic Guide:
Brief recap/discussion of last interview

This section of the interview is about your experience of your body and how you look after your body as your pregnancy advances.

Living with a pregnant body

- Perceptions of and feelings towards pregnant body
- Weight related issues
- Perception of others reactions towards pregnant body

Looking after a pregnant body

- Ways of looking after self
- Reasons for any adjustments to self-care practices
- Practices that 'should' have changed but did not
- Weight related issues

Sources of information over duration of pregnancy

- Where
- What
- Whom
- Unhelpful/helpful
- Barriers/facilitators

Experiencing health care
This section of the interview is about the healthcare that you have had so far during your pregnancy.

- Contact with health care staff/examinations/procedures
- Perceptions of relationships with health care staff
- Perceptions of judgements/expectations of staff
- Appointments that stand out/missed appointments
- Support or service that was needed but not available

Feelings towards birth plan and childbirth
In this section I would like to ask you about the your feelings about the forthcoming birth of your baby.

- Birth plan
- Anxieties/concerns

Feelings towards motherhood
In this last section I would like to ask you about how you are feeling about becoming a new mother.

- Expectations of new motherhood

Ending the interview

- Any further thoughts

Post-interview:

- Debriefing session - immediate feelings or questions discussed. Give participant the *Post-interview Information Sheet*.
- Give opportunity for participant to ask any further questions about the study.
- Thank participant for their time and reassure her about confidentiality and anonymity.
- Brief about next steps – check participants preferred means of contact to arrange next interview – check participant has contact information for the study team.

Appendix 13: Interview 3 topic guide, women

Exploring experiences of pregnancy and childbirth with women of above average weight, midwives and obstetricians

Interview Schedule and Topic Guide

Interview Three – Women 2-4 months postpartum

Pre-interview:

- Review the *Participant Information Sheet* the participant and answer any questions about the nature and purpose of the study and the format of the interview including: breaks/stopping at any time/finish another day/length interview 1 hour approximately/no right or wrong answers.
- Discuss confidentiality/limits of confidentiality/advise re disclosure and child protection policy.
- Advise participant that they do not have to disclose any information if they feel uncomfortable doing so.
- Advise participant of their right to withdraw from the study at any point without giving reason/right to withdraw all or part of their interview data.
- Ask participant to review and sign the consent form. Ensure participant has a copy of the *Participant Information Sheet* and the signed *Consent Form*.
- Direct any clinical issues to relevant clinical staff.

Interview:

The aim of this interview is to explore

- Perceptions of the experience of childbirth
- Experiences of a post-pregnancy body
- Post-pregnancy self-care practice
- Experiences and feelings towards becoming a mother
- Perceptions of health care relationships

Beginning the Story of Motherhood – Topic guide:

Experiencing childbirth

This first section of the interview is about your experience and reflections on pregnancy and childbirth.

- Type of delivery/experience of delivery/expectations
- Health care relationship/rapport
- Feelings of control/agency
- Examinations/equipment/procedures

Reflections on the experience of pregnancy and childbirth

- Memorable experience relating to being pregnant/maternity care/health care relationships/appointments/examinations/relationships with others/information/lack of information

- Anything that they wish they could have changed
- Thoughts on improvements to services/provision of services

Living with a post-pregnancy body

The next section of the interview is about how you feel about your body after being pregnant and experiencing childbirth.

- Expectations of post-pregnancy body
- Feelings towards post-pregnancy body
- Plans for the future

Post-pregnancy self-care practices

- Explore any changes/views/attitudes towards self-care practice
- Weight related issues

Becoming a mother

In this last section of the interview I would like to ask you about how you feel about becoming a new mother.

- Experience of new motherhood/mothering identity
- Perceptions of health care relationships
- Future plans

Ending the interview

- Any further thoughts

Post-interview:

- Debriefing session - immediate feelings or questions discussed. Give participant the *Post-interview Information Sheet*.
- Give opportunity for participant to ask any further questions about the study.
- Thank participant for their time and reassure her about confidentiality and anonymity.
- Give participant the *Final Post-interview Information Sheet* with details of how to get access to a summary of the findings from the study.

Saying goodbye

- Thanking the participant for their contribution to the study.
- Ensure participant has the opportunity to reflect on their contribution to the study.
- Give participant a thank you card.

Appendix 14: MHP interview topic guide

Exploring experiences of pregnancy and childbirth with women of above average weight, midwives and obstetricians
Interview Schedule and Topic Guide
Interview obstetricians and midwives

Pre-interview:

- Review the *Participant Information Sheet* with the participant and answer any questions about the nature and purpose of the study and the format of the interview including: breaks/stopping at any time/finish another day/length interview 1 hour approximately.
- Discuss confidentiality/limits of confidentiality/advise re disclosure and relevant Professional Codes of Practice.
- Advise participant that they do not have to disclose any information if they feel uncomfortable doing so.
- Advise participant of their right to withdraw from the study at any point without giving reason/right to withdraw all or part of their interview data.
- Ask participant to review and sign the consent form. Ensure participant has a copy of the *Participant Information Sheet* and the signed *Consent Form*.

Ask participant to choose a name that they will be referred to within the study.

The aim of this interview is to explore

- Practice experience of caring for women with BMIs ≥35
- Opinions and views of factors influencing bodyweight/weight management practices of pregnant/postpartum women
- Perceived practice issues involved with antenatal/intra/postpartum care of women with BMIs ≥35
- Effective communication facilitator/barriers/strategies with pregnant/postpartum women with BMIs ≥35

Caring for women with BMIs ≥35 - Topic guide:

Professional background

This first section of the interview is about your practice experience as a midwife/obstetrician.

- When qualified/what qualifications
- Previous practice experience
- Present post/hours

Previous and current experience caring for women BMI ≥35

In this section of the interview I'd like to ask you briefly about your practice experience of caring for women with BMIs ≥35.

- Practice experience with women BMIs ≥35 – capacity/role/aims/duration

- Perceptions of relationship between BMI ≥35 in pregnancy, and health care needs

This section is about your opinions and views about providing care to women with BMIs ≥35.

- Factors influencing women's body weight and weight management practices
- Perceptions of health needs of a women with BMI ≥35/differences between care of women BMI ≥ and <35
- Perceptions of typical pregnancy for a women with BMI ≥35
- Facilitators/barriers to providing ante/intra/postpartum care to women with BMI ≥35

Caring for women with BMIs ≥35 (for obstetricians/midwives providing intrapartum care only)

In this section I'd like to ask you about providing intrapartum care to women with BMIs ≥35.

- Perception of specific health/safety needs during delivery
- Experiences of typical delivery scenario – detailed examples of
- Facilitators/barriers to providing effective care/examples of specific role in weight management support

In this next section the focus is on weight management for women with BMIs ≥35.

- Perception of current role in antenatal/postpartum weight management
- Facilitators/barriers/feelings towards to perceived role
- Weight-gain in pregnancy
- Perceptions of facilitators/barriers to women's engagement with lifestyle interventions
- Perceptions of services/support provided to women with BMIs ≥35 (antenatal/intra/postpartum)

Talking about weight related issues

In this last section I'd like to ask you about how you feel about talking to women about weight related issues.

- Advice offered to women about weight related issues (including birthplan)
- How the subject of weight is broached with women
- Effective strategies used to facilitate effective communication
- Any areas of challenge/discomfort

Ending the interview

- Any further thoughts

Post-interview:

- Debriefing session - immediate feelings or questions discussed.
- Give opportunity for participant to ask any further questions about the study.
- Thank participant for their time and reassure her/him about confidentiality and anonymity.
- Give participant the relevant Post-interview Information Sheet with details of how to get access to a summary of the findings from the study.

Appendix 15: Sample analysis

This is an example of the structural analysis I conducted on the storied data contained in the transcribed interviews. The story is entitled ‘I don’t need any of that! and was told by Sarah a consultant obstetrician during a section of interview talk discussing how some larger women resisted enhanced medial assessment.

I have TWO cases
that are particularly memorable //

ONE was a lady
I saw at 28-weeks
who was BMI of 40.1 //

and erm
was CONVINCED that
she'd LOST weight //

and by the time
she was 28-weeks
when we were saying
“well you SHOULD
have your OGTT
and you NEED to go to
the anaesthetic clinic” //

erm she INSISTED
on having her BMI REcalculated
which was 39 point something //

and SHE said
"well I don't NEED
any of that" //

and erm refused ALL input
um from that
and was very VERY
VERY defensive
um about it //

erm she had different issues
regarding her pregnancy
and the weight was on TOP of that //

she wanted everything
to be NATURAL
and SHE felt
that it WASN'T//

319 but erm
320 there was very much
321 just a
322 it was a challenge //

323 and it was
324 and she BECAME
325 not aggressive
326 in a HORRIBLE
327 but VERY defensive //

328 and it was just like
329 "FINE
330 I can only TELL you
331 what I would recommend //

332 if you CHO:OSE
333 not to do that
334 then that's ENTIRELY
335 up to YOU" //

At the first reading of this story Sarah might be understood as being intolerant of the women's efforts to avoid increased medical intervention. Sarah also seems to signal a withdrawal of emotional support from the women (lines 328-335), suggesting she feels there is no more she can do. However, as the analysis and interpretation develops, using the methods which I will I described in Chapter 5 it is possible to see there is some distance between *what* Sarah says and *how* this relates to the context she finds herself in.

The analysis began with a structural analysis of what the story was about. This aspect of the analysis reveals something about how Sarah sees herself and her role as an obstetrician in relation to the larger pregnant woman in the story. This aspect of the analysis involved identifying the story characters and analysing the positionality of these characters in relation to what is happening in the story.

The **protagonists** in this story are the obstetricians who are portrayed as doing their job in a matter of fact manner. The obstetricians are characterised as rational and level headed: in that they are portrayed as making a simple request that the woman has screening. Sarah uses "we" to suggest that obstetricians are a homogenous group which seems to give them an air of authority, suggesting that they represent the profession of obstetrics, in relation to their recommendation the woman undertake further screening:

297 when we were saying
298 “well you SHOULD
299 have your OGTT
300 and you NEED to go to
301 the anaesthetic clinic” //

The 28 week pregnant woman is characterised as the **antagonist** and is portrayed as being challenging, insistent and “defensive”; suggesting that she is difficult and less than rational by refusing “all” input:

302 erm she INSISTED
303 on having her BMI REcalculated
304 which was 39 point something //

305 and SHE said
306 "well I don't NEED
307 any of that" //

308 and erm refused ALL input
309 um from that
310 and was very VERY
311 VERY defensive
312 um about it //

Her character is further developed as a woman with “issues” who wanted a “natural” pregnancy. The fact that these issues are not described, but left to the imagination of the listener, appears to cast further doubt on the moral character of the woman. In addition to this, the woman is portrayed as lacking awareness or ignorant about her situation as “she wanted everything to be natural” despite the obstetricians’ recommendations:

313 erm she had different issues
314 regarding her pregnancy
315 and the weight was on TOP of that //

316 she wanted everything
317 to be NATURAL
318 and SHE felt
319 that it WASN'T//

The **conflict** central to this story relates to the obstetricians’ recommendations and the woman’s response. The woman is advised that she “should” have an OGTT, and “need[s]” to go to the anaesthetic clinic, however the woman is insistent that recalculations of her weight be done so that she can avoid the screening procedures. As an obstetrician, Sarah makes clear here how she feels about this particular situation making it clear that she thinks that larger women may not act in their own best interests. Furthermore, she indicates that should larger women become defensive, they are difficult to manage. Faced with this situation Sarah

indicates that obstetricians lack power. And although the woman is not being "horrible", Sarah finds her defensiveness challenging in itself.

The feeling of powerlessness manifests in the **resolution** of this story and involves the backing down of the obstetrician:

328 and it was just like
329 "FINE
330 I can only TELL you
331 what I would recommend //

332 if you CHO:OSE
333 not to do that
334 then that's ENTIRELY
335 up to YOU" //

Use of the word "fine" indicates how Sarah feels about the woman exercising her choice not to have the additional screening. She emphasises the woman's right to make a choice, and her feelings are clear in reluctantly accepting the woman's decision. She also at this point seems to emotionally withdraw from the woman, or the situation. We do not hear about what happened to this woman as a result of her decision, therefore this is not a moral story about what happens if you ignore obstetric advice, but is rather a story about how challenging the obstetrician finds larger women who want to avoid medicalisation.

When I began to analyse the structure of this story I was aware that the obstetrician's attitude towards the woman looked quite negative on paper, and she seemed to be withdrawing support from the woman. The early analysis of the story presents a straightforward analysis of the story structure identifying the characters (protagonists and antagonists), conflict and resolution. In itself this structural analysis is incomplete, in that it falls short of *interpretation*, which reveals the meaning of the story (Ricoeur, 1991; Gee, 1999). Interpretation, therefore, involves a further structural analysis of *why* and *how* the story was told.

Further interpretation of why Sarah told this story is found from clues within the wider interview text as well as from the story itself. Sarah seems to be making the point that she really has little power if a woman chooses not to accept her recommendations for additional screening. As she casts the woman as less rational than herself she indicates that she feels that women are prone to making what she feels is the wrong choice, and this only serves to add to her feelings of powerlessness; in that there is little she perceives she can do in this instance,

suggesting she may feel somewhat trapped. It is interesting to note that the woman's attempts to avoid additional screening procedures, and therefore medicalisation, perhaps expose the nonsensical nature of the screening protocols, at least from the woman's perspective. As larger pregnant women seem to be 'less than rational', communication with pregnant women, especially where there is the possibility of a woman becoming defensive, may be particularly problematic for obstetricians and perhaps, to some extent, feared. In this sense communication presents as a risk to obstetricians. The story seems to imply that once a woman becomes defensive then obstetricians may feel that they are somewhat at the mercy of the women they care for. Narrative data from elsewhere in Sarah's interview suggests that, as the obstetrician must manage any future pregnancy or birthing complications, it is particularly challenging when women become opposed to their suggestions for how to make choices relating to giving permission for medical input. Therefore, persuading women to accept medicalisation is an area of the obstetrician's work with a particularly high emotional investment.

Story topics/subjects

Women's irrationality/ignorance

Defensiveness

Power

Communication/information-giving

Appendix 16: Sample of verbatim quotes used in monologues

(Bold text indicates verbatim quotes)

When I was first a midwife in **1997 it used to be a real shock when someone with a big BMI came in**. But now **it's every third or fourth person**, and **we've had to get new beds and wheelchairs** and everything. **I blame junk food**, and often I'm shocked at the general **lack of knowledge that some women have about eating** properly. Like this woman I booked a while ago. **Her BMI was 45, and so when she came for her second visit I got out my special pink leaflet: the one that tells you how to replace unhealthy foods and drinks with healthy ones. It's really brilliant and I use it along with the *Ready steady baby!*[62] book to help me explain healthy eating to them**. Anyway, this particular woman thought **she was doing well. She'd swapped her 2 litres of full fat coke for 2 litres of fresh orange. I mean she had absolutely *no* idea what she was doing and I thought, "you'd be better sticking to the coke!"**

She thought it was healthy you see, and she's not alone, **I get a lot of Indian and Pakistani women who eat rice three times a day and think that's healthy**. **It's *shocking* the amount of carbohydrates some people eat, so I tell them to cut down on the rice and increase the chicken. It's a shame more of them don't watch these programmes on the telly, the ones that tell you the secrets behind the food we eat.** So with big women, a lot of **it is about educating them**. **It's a bit hit and miss though, and sometimes they shut off**, but others are quite open to it. I think **a lot of them don't realise how heavy they are until I weigh them and then the penny drops!** But I think **some of them aren't interested in watching their weight when they're pregnant, they just think they're going to put on weight anyway**. But **when the bigger girls lose weight it's usually because they're watching what they eat**.

I've **never had any problems with my weight, and I don't even know what my BMI is, so I'm never very sure how to talk about size.** I think the best way I've

[62] The *Ready, steady baby!* book is a free resource distributed by midwives to pregnant women. It is funded through NHS Health Scotland and provides information about pregnancy, childbirth and parenting (see http://www.readysteadybaby.org.uk/index.aspx).

found is to wait until they describe themselves, and then **I use the same terms. They might say, "cuddly" or, "there's a bit more of me". I don't use obese, I think it's a horrible word**. Being careful about what I say helps, especially as we've got to weigh them. **I get a lot of scale dodgers. The good BMIs don't mind standing on the scales, they're the ones who've always watched what they're eating. But the one's that know they've put on too much are always pleading to avoid the scales, saying, "must we?" So they know they've put on too much. I think some of them eat for two or spend their maternity leave sitting around eating, and then they're keen for me not to tell their partners what they weigh. They get embarrassed, especially about the size of their breasts, which I think stops a lot of them breastfeeding: they can't imagine ever being able to breastfeed in public.** Anyway, **it's always the ones who haven't put on too much that want to stand on the scales, and I'll say to them, "oh wow, excellent! You've only put on 5, or 6, or 10 kilos". They're my good BMIs. With the ones that have put on too much, I tell them to cut down what they're eating for the next couple of weeks.**

The **bigger girls tend to get bigger with each pregnancy, and by the time they come for their third they've put on about 30 kilos**. It tends to **run in families too**. **I've got a 19 year old just now who's got a BMI of 45, so she didn't get like that overnight. I blame all the fast food we have in this country: chip shops, kebabs, pizzas, deep fried pizzas, deep fried mars bars, all washed down with a diet coke to make us feel better. It's not like that in other European countries. But actually people are just lazy, you know: going to *Farmfoods*[63] and buying something that you can stick in a deep fat fryer, or in the oven. They think it's better than going to the supermarket and buying mince to make a nice chilli con carne with a wee bit of rice.**

[63] Farmfoods is a frozen food supermarket chain based in the United Kingdom.

Appendix 17: Kacey's monologue

Early pregnancy

Right in the middle of planning my wedding I find out I'm pregnant! This isn't my first pregnancy; I had a miscarriage a couple of years ago when I was in another relationship. After that relationship ended I worked really hard and managed to get my weight down. I was quite slim and I felt more confident, well, better than I felt during my childhood; you know how horrible kids are? I've always been big, so it was nice to be slimmer. I met Craig and all was going fine, I managed to keep the weight off, but then I started having terrible mood swings and headaches, and I was bleeding all the time. So they changed my pill and all the weight I'd lost just piled back on again. You know this can happen with the pill, but I wasn't expecting all the problems I had with craving sweet stuff. I used to ask Craig to drive me to buy chocolate late at night, my body felt out of control. They told me to come off the pill and use condoms instead, just to tide us over until after the wedding.

Even before the miscarriage I had this deep fear that I wouldn't be able to have children. I don't even know where it came from, and I suppose having a miscarriage didn't help that. It was like a deep uneasy feeling that I couldn't seem to shake. Anyway, after coming off the pill I did suspect I was pregnant, but I hardly dared to think that it might be true. It was quite weird, like a struggle between what your body's telling you, and a fear of letting yourself believe that it might actually be happening. I did 5 pregnancy tests in the end, just to make sure. The first ones I did were negative. But by 5 weeks there was a faint line. Craig's family said: "it's too early, anything can go wrong, so don't get your hopes up". But my family were really excited and my mum told everyone. I wasn't too happy about that because you're not meant to tell anyone until after 12 weeks.

Even when I phoned my GP practice I still believed there was nothing there, but they just told me to make an appointment with the midwife. The midwife sent me to the hospital for a scan and there it was, a tiny movement on the screen. I could hardly believe there was something in there. I cried. It was relief really.

The scan was just the beginning. Once I knew I was pregnant I just worried all the time. Those first weeks were a bit of a nightmare to be honest. I was convinced that I would do something wrong, that something would hurt the baby. I'd been told not to lose any weight but I did lose weight in the beginning, I couldn't keep anything down. Of course I put it all back on again and now I'm worried about what size I'll be at the end.

Late pregnancy

I never got my proper pregnant belly, the one everyone else seems to have. I'm just fat all over. It's just as well I can feel her or I don't think I'd feel pregnant at all. So much for looking beautiful in pregnancy! I can't even get clothes to fit me, well not nice ones anyway and ones that I can afford. I'm in agony with so much pain in my back and I really wish it was over: I just want her out. I've put on so much weight, and my body is swelling up with fluid so much that I hardly recognise myself any more. Even walking around is difficult; I just waddle like a penguin.

I think with feeling so huge makes it more difficult to accept that you're not allowed to have a relationship with one midwife who'll be at the birth. You're not even allowed to go to the hospital and meet the midwives on the labour ward. So when I'm in labour the people who are going to be seeing everything will be complete strangers. They've told me all about what'll happen when they induce me. They put something up to ripen the cervix which apparently takes 24 hours. Then they take you through to the labour ward to break your waters, and then they put you on a hormone drip to quicken up your contractions. I'm pretty much dreading all that, especially as while you're waiting for the induction to work you're just in a normal ward with about 6 other women, so people are going to hear you in pain. I don't want to hear other women in labour and I don't want people staring at me or hearing me. While I'm being induced Craig won't be able to stay with me all the time, so I'm going to be going through such a hard thing and he won't be there.

5 ½ months after childbirth

In the last 2 weeks of my pregnancy I'd been back and forward to the hospital with high blood pressure. I kept saying that I wanted to go home because I hate being in

hospital. Anyway, because my blood pressure was high they brought forward my induction to 37 ½ weeks saying that the baby was better out than in. I wasn't too bothered about it because I'd had enough by then anyway and my feet were so swollen I was only leaving the house to go to the doctors. Not that any of them were much help, they just put everything down to your weight.

The ward where you get the induction has 6 beds with just a curtain in between so there's not much privacy. It was just my luck that I got the midwife who never smiles, I feel uncomfortable around her because I think she's looking down on me. Anyway, she's one of those ones who know how they like things. She has *every* curtain open at 7 o'clock in the morning: not just open, but tied back. I kept closing the curtains and she kept coming back and opening them again and I realised with horror that I'm going to be in pain with everyone staring at me!

The girl in the bed opposite had been induced and was screaming in agony. She was crying and going back and forward to the toilet. She was asking to go to the labour ward, but there was no space so she wasn't allowed to go. She was on her own because it wasn't visiting time. I mean imagine making you go through all that on your own! Anyway, they just kept telling her to calm down. It was horrible to watch, I felt so sorry for her, and it made me more worried about people watching me in pain.

My induction worked really quickly and my waters broke after about 2 hours. I did my best to be as quiet as possible but eventually after bouncing on my ball thing for what seems like ages I just couldn't cope with the pain any longer. Well, I couldn't cope with the fact that I could hear them all listening to me, and whispering about me. I asked for morphine, go to sleep, and everything stops.

In the morning I'm sent to the labour ward and they hooked me up to all sorts, a fetal monitor, a drip to make labour start and one with antibiotics for the infection I had because my waters had gone. I was scared. The only thing that helped with the pain was sitting up and bouncing on the ball, but once I was in the labour ward I couldn't do that, so I took the morphine. The doctors kept coming in and saying "you should have an epidural, just have an epidural" and I was like "I don't want one". Two of

them had an argument at one point; one was shouting that they needed to give me a C-section because I was in so much pain and it was going to be ages yet. The other one was saying: "no we're not giving her a C-section". They were so busy arguing that they wouldn't listen to me. Then they said: "we'll let you think about it". But it wasn't long and they came back in and they were just pushing me to do it. So I just said: "fine do what you want".

It took an hour to get the epidural in and I ended up regretting agreeing to it. I didn't like not being able to feel my legs, I was uncomfortable because I couldn't move in the bed and the midwives wouldn't help so Craig had to keep trying to lift me up. After a while it stopped working and they said that I could get another one but I said no. They ended up giving me more morphine.

In the end I had a forceps delivery but at least I avoided a C-section. I know that next time I'll be doing what I want to do not what they tell me to do, well to an extent. I think with a first pregnancy you don't know what to expect and so you just do what they tell you. Next time I wouldn't have an induction so early, I'd want to just wait myself and be in labour at home for as long as possible, then they can strap me up to whatever they needed once I go in. That was the worst thing for me, not being able to move, not being able to walk around. I know a lot more about labour now so I won't be scared to tell them that I don't want an epidural or anything like that, and I won't back down.

Appendix 18: Nicola's monologue

Early pregnancy

I was 8 weeks pregnant when I saw the midwife, so she did both the booking appointments at once, and it was a lot to take in. I was feeling really sick and dizzy at the time so it's all a bit hazy. But I do remember I asked her about healthy eating and diet, not because there's anything wrong with what I eat, but because I'm bigger and I thought I should. I knew that there was a pretty high chance that she thought I was lazy or ate rubbish. I say I'm not bothered what people think, but I suppose being a bigger girl you're always in the spotlight.

It seemed ages until I got my first scan. I think at that time I felt really alone, which is not really like me. Time just seemed to pass so slowly. Part of me didn't want to have the scan in case there was nothing there, but I knew I had to go. I'm sure everyone feels a bit like that - you know, you hear people talking about how great it is to see the baby, how real it makes it, but I was so convinced that I wasn't going to be able to have children I was overwhelmed by it all. The sonographer had a trainee with her who did all the scanning, which was fine. They all seem to be training someone so you get used to that. She explained the whole scan to me and I was really emotional. It was such a relief, a relief that there was a baby in there kicking its legs around, and a relief that they were nice to me.

The community midwife said I'd have to see the doctor at the hospital antenatal clinic. So when the appointment came through I knew what it was. I wasn't too worried about the thought of them talking about my weight or anything; they feel they have to do it, and I think it's just something that I have to accept. The doctor told me that I'd need extra scans because the midwife wouldn't be able to tell if the baby was growing. I don't mind the thought of having extra scans though because they're so reassuring. She said I also need to have a pregnancy diabetes test too, I'm not quite sure why, but if they think I need it, then I'll just do what they recommend.

Late pregnancy

Since I got over the early pregnancy sickness I've not really had any problems at all. I've had quite a few appointments with different people for tests and scans. The

diabetes test was negative, but apparently I need to have it done again next week because they're worried that there might be extra fluid around the baby, or something like that. I suppose I feel like I have to just go along with it all, you know, I've never been pregnant before and I just think that they're the professionals, so I just trust what they say.

I saw the anaesthetist yesterday. Her opening line was: "do you know why you're here?" Actually I didn't, so she had to tell me. Apparently, if I need pain relief in labour then it's better to have it sooner rather than later, I think it's something to do with it taking longer to get round my system because I'm bigger. I wasn't really sure about the epidural, and I hadn't really thought about it before I saw her, but she said that if I need a C-section then it's much easier if the epidural's there.

I don't like the thought of an epidural, I've heard stories where people never walk again, but I know that's the worst that can happen. I don't like the idea of not being able to feel your legs or walk, even for a short time. But the anaesthetist said that you still feel the contractions, which is reassuring because at least you know when to push. So that feels a bit better. She looked at the veins in my hands and arms and then asked to look at my back and she showed the trainee where they would put the needle in. That was it really; she gave me a leaflet and told me to think about it. So really it's my choice, if I choose to listen to them. As I say, I've not done this before, so I'm quite open about what's best to do, and when it comes down to it I just want to do the safest thing for the baby.

It's weird though, there's no information about bigger women having natural births, so I don't even know if it's possible or not. Let's face it, it's the professionals who tell you what to expect. So when they recommend you have an early epidural and you follow their advice you're never going to know whether you would have needed it or not. I suppose though, when it comes down to it, I just want him out as quickly and as safely as possible. At this point in my pregnancy I think that if I could do it all again I would rather be smaller having a baby, then I could have avoided all this.

7 months after childbirth

I was 12 days overdue when they took me in for the induction. I knew that I had to have an open mind about everything because I'd never done it before and I suppose I'd just braced myself for going in to the hospital. As soon as I got to the labour ward I asked for an epidural because I was convinced that I was going to have a caesarean. And then being bigger as well I knew people would judge. But it wasn't like that though, in the labour ward at least, they couldn't have been nicer or more helpful. The anaesthetist talked to me constantly, explaining what he was doing and the midwife kept me calm. I really felt cared for. Even moving me when my legs were numb was okay, it was a bit of a performance and at first I thought: "how on earth are they going to do it?" But they just moved me on one of those hover mattresses.

I was so ill after the baby was born. I'd had all these problems with the epidurals, they couldn't get the first one in and then later it came out. Then I had a spinal anaesthetic and forceps. I lost a lot of blood and then they thought I was developing septicaemia so I was kept in the labour ward overnight with a one-to-one midwife. I was hooked up to all sorts, and missed out on giving Oscar his first feed and bath. Rob did all that.

I think the hardest part of all of that wasn't so much the trauma of it all but the way I felt in the postnatal ward. Looking back I really wish that I'd never been there at all. After all the fuss with all these people round me constantly, telling me what's happening and being so nice to me, I was just sort of abandoned on this ward and nobody came and spoke to me at all. The first night was the worst, Rob had been ushered out the door and no one came near me. I was trying to look after a baby with a cannula in each hand and a catheter. I was tired and getting more stressed by the minute. I kept buzzing for the midwife and she said: "you don't need to buzz for that, you just do it yourself". Well, how could I when no one had even shown me where the milk and the bed sheets were? It's like they want you to struggle. The next day was different though and a really nice girl, well I call her a girl she was quite young, she spent ages with me, told me where things were and just to help myself. It's what I needed really, someone spending just even two minutes with me.

I've not been well since I had Oscar, it's been months really. Some of the feelings that I'd had in early pregnancy returned and I became a bit of a hermit. Eventually

Rob told my mum how unwell I was and they persuaded me to see the doctor. I think that being bigger is what made me have the dips I had after I had him. Looking back I know that I bottled things up, I have a tendency to do that. Later on when I was feeling better I found out that one of my friends had felt as low as me, but she didn't mention it to me before I was ill; so I suppose it's the sort of thing no one talks about.

If you were to ask me if I'd do it all again and have another baby I would say no, definitely not, not as a bigger girl anyway. I don't want to lose loads of weight, which I know sounds a bit strange because everyone seems to want to be thin but I was always the biggest out of all my friends at school. So I've always grown up with that and accepted it as I think it's part of who I am. I suppose being pregnant has changed the way I think about myself, not because I want to be smaller, but because I wouldn't like to be back in that situation. It's just that it must be a lot easier being an averaged sized person.

Appendix 19: Vron's monologue

Early pregnancy

On a Friday in December the doctor phoned me and said the reason I haven't been having periods is not because of any problem with my hormones, it's because I'm pregnant. My immediate reaction was to cast my mind back to what I'd been doing in the last couple of months. I remembered all the weddings and hen nights[64] I'd been to, and how much alcohol I'd drank. I was horrified. I imagined that anything could have happened to the baby. I was in shock and needed time to think about what to do. On Monday I phoned the doctor and said I would definitely be keeping the baby and he said: "book yourself into see the midwife as soon as you can, take folic acid and don't touch cat litter or eat any pate or cheeses".

I couldn't get an appointment with the midwife for a month which was hard as I was really worried I'd harmed the baby. I was 13 weeks and 4 days pregnant by the time I had my scan, and at that point I was already quite stressed about my weight, thinking: "what am I doing, how is this affecting the baby?" To make things worse, my mum, and my partner Jack were wrapping me up in cotton wool, and to be honest the strain of keeping my pregnancy a secret was beginning to tell on me; I was so worried and I felt like I had nowhere to turn. As it was going to be a whole month until I saw the midwife I went out and bought a book which told me what not to eat. I suppose I feel that eating the right things is one of the things I can actually control. I know that I'm going to put on weight and that's going to put even more of a strain on the baby but unfortunately you can't go back in time.

Late pregnancy

It wasn't until I had my 20-week scan that I stopped worrying so much about whether the baby was okay. I can't tell you how relieved I was to hear the sonographer say: "everything looks fine on scan". After the 20-week scan I was scheduled to have a growth scan a few weeks later. After the growth scan the consultant sat me down and said: "right your baby's big, you'll have to watch what you're eating". It turns out that the baby's growth was on the mid-line at the 20-week

[64] A 'hen night' is a UK term for a party for the female friends of a bride prior to her wedding.

scan, but now it was at the top. So he was like: “have you been eating properly? Have you been having sugar in your tea? Have you been drinking sugary juices?” And I'm just like: “well, you know, I’ve done my research and my diet’s pretty good”. Talk about being in the hot seat!

I’ve noticed people keep an eye on what I’m eating. I had some snacks at a party the other week and someone said: “is that you eating crisps[65]?” People also stare at you and make comments about the size of your bump, which I find really difficult, because that’s were I carry my weight, so I’m really conscious of it.

They’ve said that because the baby’s big they won’t let me go to term. So the midwife said that she’d do a sweep at 39 weeks which she did. Not much seemed to happen though, and by the time I saw the consultant a few days later I was getting quite panicky about what was going to happen and whether the baby was okay. So when the consultant greeted me with: “what can I do for you today?” I told her I wanted to be induced. “It’s not procedure” she says, and I was like: “you’ve told me all the way through my pregnancy that my baby’s really big, you’ve told me that you won’t let me go to term”. She said: “it’s not procedure”, and anyway, because of my size, the scans are not accurate. I couldn’t believe it; I had been worrying all along about my body, about how my body would affect him. I trusted the health professionals; I relied on them. And so, to be told that the scans weren’t accurate, to be getting totally different information at this late stage, was she right? Were all the other doctors scaremongering? Has it been drummed into them: scare the bigger women? They were going to leave me for another 12 days which made no sense to me, I mean, I know he’s not gaining a pound everyday, but even an ounce a day it going to make him even bigger.

10 weeks after childbirth

The section about obesity in the NHS pregnancy book says that you’re at higher risk of a smaller baby or a bigger baby, diabetes and all that. I’m also preparing myself for the fact that I might need assistance with the delivery, but I’m trying to keep it all in perspective. Complications happen to people who are classed as normal weight.

[65] What are referred to as crisps in the UK, are otherwise known as potato chips.

Some of my friends have had stuff happen to them, I just happen to be five stone over weight, but I'm also a lot healthier than some of them. I don't know, maybe all this talk about the size of the baby is just a way of getting people to lose weight before they get pregnant?

You're not induced in the labour ward; you're in a ward with just a curtain between you and the next person so you hear everything. The woman next to me was in full-blown labour and was on her own. I heard everything; I even heard her waters going. I hated it, I just wanted to go and hold her hand. I didn't realise at that point that I would be in the same position as her a few hours later when my labour got going. It was awful, I was in such pain and Jack wasn't allowed in, he was in the corridor wondering how I was getting on. Right up until I had my baby I wanted to keep things as natural as possible. As it turned out he was in the back to back position, but I didn't find that out until I well into my labour.

It changed everything and now I feel like it was crazy to even make any plans for how I wanted things, and after wanting everything to be natural I ended up with an epidural and forceps. At one point I thought I was going to have to get a c section, but then they changed their minds because he was so far down that it was too complicated because they would have to go past my bladder, so they recommended we avoid it. Anyway, I had forceps, I just remember seeing all the blood and what had happened was that they had cut me and I also tore, Jack said they dropped one of the forceps. He wasn't even a big baby, I imagined by the way they went on that he would be a 14 pounder; he was 8 and a half pounds.

Appendix 20: Anna's monologue

Early pregnancy

Once I got past all the early worries, new ones came along. I saw the midwife at the antenatal clinic and she weighed me. "You've gained 2 and a half kilos, but we don't expect you to put on anything until 6 months", she said. She was upset, so that sort of upset me. I think I'm doing all the right things, I stopped smoking the minute I found out I was pregnant, so I don't know how I'm supposed to not gain *anything*!

Although I had loads of questions for her about pregnancy sickness and food cravings, we had the usual conversation: she lectured me like a baby and told me all about counting calories: "It depends how much you move about", and all that: nothing I don't already know. In fact, the whole conversation made me think that she wants me to live on grass and water. I wondered if she's ever been pregnant, ever had food cravings, ever felt like your body's been taken over by aliens? She told me to go swimming, which I'm definitely not going to do, I don't fancy getting a urinary infection from the public baths. That was it really; bit of a one-way conversation. She gave me a leaflet, and I thought: "shame it's not like that in real life!"

I did a lot of research after that, and found out that if you gain too little weight it can harm the baby, it can even cause disabilities. I also found out that I can't go on a diet: it's too late for that. So I need to deal with whatever, and do whatever I can. I think I'm only allowed to gain 9 kilos, which is a lot less than slimmer girls, so I signed up for this *Change your life in 30 days* Facebook page. It's like having your own personal trainer; you do all these exercises right in your living room and learn how to eat smarter. It's all about choice you see. I had some kind of Chinese couscous chicken yesterday, I thought it was a bit too spicy, but I thought maybe I should get the baby used to having spicy food, you know, save me training her later.

I'm having extra scans to monitor her size because she's bigger than average, apparently she has long legs! I found out from one of my friends that everyone's stopping taking pregnancy vitamins because they make the baby put on weight. Anyway, I'm not keen on the idea of a C-section so I stopped taking mine too. I've been tested for the kind of diabetes you get in pregnancy but it was negative. I was a

bit surprised, especially with all the talk about big women getting it. I'm getting a lot bigger now though and people are asking me if I'm having triplets. I just laugh it off but actually it's a strain being this weight. The doctors don't really say much, they just write 'higher BMI' on your notes.

Late pregnancy

Once I got past all the early worries, new ones came along. I saw the midwife at the clinic and she weighed me. "You've gained 2 and a half kilos, but we don't expect you to put on anything until 6 months", she said. She was upset, so that sort of upset me.

I think I'm doing all the right things, I stopped smoking the minute I found out I was pregnant, so I don't know how I'm supposed to not gain *anything*! Although I had loads of questions for her, we had the usual conversation: she lectured me like a baby and told me all about counting calories, "it depends how much you move about", and all that. Nothing I don't already know, in fact, the whole conversation made me think that she wants me to live on grass and water. I wonderd if she's ever been pregnant, ever had food cravings, ever felt like your body's been taken over by aliens? She told me to go swimming, which I'm definitely not going to do, I don't fancy getting a urinary infection from the public baths. That was it really. A bit of a one-way conversation. She gave me a leaflet, and I thought, "shame its not like that in real life." She didn't tell me what I most want to know: "have I put on too much weight or too little, and how do you deal with cravings?"

I did a lot of research after that, and found out that if you gain too little weight it can harm the baby, it can even cause disabilities. I also found out that I can't go on a diet: it's too late for that. So I need to deal with whatever, and do whatever I can. I think I'm only allowed to gain 9 kilos, which is a lot less than slimmer girls, so I signed up for this *Change your life in 30 days* Facebook page. It's like having your own personal trainer; you do all these exercises right in your living room and learn how to eat smarter. It's all about choice you see. You just choose the salad; it's not about comfort food anymore.

I'm having extra scans to monitor the size of my baby, because they say that she's bigger than average, apparently she has long legs! I stopped taking the pregnancy vitamins after my friend told me that everyone's stopping them because they make the baby put on weight, and I'm not keen on the idea of a c-section. They tested me for diabetes, the kind you get in pregnancy and it was negative, I was a bit surprised, especially with all the talk about big women getting it. I'm getting a lot bigger now and people are asking me if I'm having triplets, I just laugh it off but it is hard moving your body around when you're this weight. The doctors don't really say much, they just write 'higher BMI' on your notes.

3 months after childbirth

I was admitted to hospital 4 times with terrible pain in my back. It was awful, the pain was awful but what was worse is that I felt that they treated me like a great big whale. Eventually I saw a doctor who talked to me like human to human, and she told me that the pain is being caused by her being big and lying back to back with me. You can imagine that by 39 weeks I'm keen to get her out of me. So when I see my consultant, and she says she's going to leave me until 42 weeks because of the risks of induction, I demanded to see someone else "I can't do this anymore" I told her. At 40 weeks, when I saw the other doctor she said my cervix was beginning to open up, so they took me in. I still can't really talk about what happened because I'm still tearful about it, and angry. So I'm not going to say much about the birth, except to say, I was in labour for 25 hours, and with her facing the wrong way, they had to use rotational forceps to turn her. But it was what happened after I had her when I was in the post-natal ward that was the worst.

After she was born, they took her to the neonatal ward because they thought she had an infection and needed antibiotics. The neonatal ward was across the other side of the hospital from where I was on the postnatal ward so it was a bit of a trek to go and feed her. The first 24 hours were fine they took me to see her in a chair which was great as I was dizzy with losing so much blood. I know the policy is to get people mobilising, so I can understand them wanting to make me walk around, and anyway, I had the injection and the socks to prevent blood clots. But what I don't understand is why I was left to walk the hospital corridors feeling faint because none of the staff

would walk with me: it's almost like they think you can just have a baby then run a marathon. Don't get me wrong, there are lovely midwives, but there are also horrible ones too. The lovely ones spend 30 seconds longer with you, they feel like your mum or your grandmother. I don't think I'll ever forget the midwife who brought a bowl of warm water and washed my face when I was too exhausted to do it myself. Some of the rest of them just think you're lazy, so I think they don't really want to help you. I wasn't being lazy. I was just massively tired and weak. It's not surprising really that a doctor found me almost fainting in the corridor she just said "ok you can go and see you baby but you can't hold your baby", so I think the support is not really there.

Appendix 21: Susie's monologue

Early pregnancy

It took 5 years to get pregnant because of my polycystic ovaries. My doctor referred us to the infertility clinic in the summer but I found out I was pregnant before my appointment in November. It was one of the best days, well apart from getting married. When I did the pregnancy test before taking my provera[66]. I couldn't believe it was positive. I phoned the doctor and she said: "if it says positive, it's positive. You can do another test in 5 days, but no, congratulations, you're pregnant!". Don't laugh, but I did 7 more in the end and when Bill came home I screamed downstairs: "come here, come here!"

The community midwife said that as part of the booking process they have to ask you about your weight and diet, so I mentioned that I've been going to Slimming World. I've lost 3 stones. She said she doesn't recommend me losing any more weight; I just have to stay as I am. She showed me where my weight is on her BMI chart, and said I'm in the obese category, so nothing I didn't know before. I've always been bigger, I was big as a child although we always ate well at home. She said: "it's the guidelines" and so I think she's just doing her job. I don't think she could have been any nicer to me, she gave me her contact details and said if I was worried at all I was just to ring her. So really I feel quite lucky, you know it's my first pregnancy so I'm not really sure what I'm doing. She also said I can have midwife care even though my BMIs over 30. I think I do have to see the obstetrician, but most of the time I'll just see her.

After all the excitement of finding out I was actually pregnant and getting booked in for all these appointments you just seem to fall into a chasm where nothing happens. Time seems to go really slowly and everyone keeps saying to me, "once you get to 12 weeks you'll be fine". But your first trimester doesn't end until 13 weeks and 6 days. What's worse is that sometimes I don't feel pregnant, I don't feel sick and I don't feel tired, and I'm thinking: "should I feel actually normal?" I guess I'm just

[66] Provera is an oral medication taken to help regulate ovulation.

kind of in limbo waiting for my next scan at 20 weeks so I can see if everything's okay.

Late pregnancy

After feeling like nothing much was happening things kind of speeded up and I think I've had 8 scans now. I also had a bit of a scare when the letter with my blood test results arrived and it said the baby didn't have Down's syndrome but it might have spina bifida. Luckily I only had to stew over the weekend until I had the scan with the consultant on the Monday. My husband was saying: "we'll just cope with whatever happens", but I had all these scenarios going through my head about how we'd manage. Anyway the scan showed that everything looked fine, and the consultant said, "don't worry, they'll also check again on the 20-week scan".

I've had to have quite a few repeat scans because the baby's never lying properly so they can't see what they want to see. I feel lucky that I'm entitled to these extra scans, but at the same time I feel guilty that I'm taking too much from the NHS. You know, someone might be going without because of me. The other thing is that with going to the hospital all the time I'm also missing out on seeing my community midwife. I did see her last week because I phoned her because I was worried the baby wasn't moving. She said: "come straight down". She had a quick listen to the heart beat and everything was fine. I'm trying not to do the 10 kicks a day thing because it just makes me worry, my baby moves and stretches but it doesn't really kick.

I saw the anaesthetist last week because of my BMI. They're worried that the baby might grow too big, that's why I had to have the glucose test, I think with a higher BMI maybe your body doesn't break down the sugars and you pass them onto the baby. Mine was okay but the baby's measuring a bit bigger just now, it's head and legs are ok, it's just its abdomen they're worried about. Anyway, the anaesthetist said it's safer to get an epidural in as soon as I go into labour because if the baby gets stuck then they can rush me straight into theatre. He reeled off some statistics and gave me a website where I could check out what he'd said. But I didn't feel like I had to go and check, I think if someone can reel off all that information then they pretty

much know their job. Anyway, he said its better to be safe than sorry, but it's up to me. Actually, I think it's a bit of a 'no brainer' to be honest; you can't argue with statistics and I'm not risking the life of the baby, and I'm not risking the baby growing up without a mum for the sake of an epidural.

Luckily the baby's growth has slowed down now: well its stomach has stopped growing, so they're going to let me go to 40 weeks. I was worried what I could do so I don't make things worse but the midwife said not to worry, the baby will only take what it needs and I get the rest. So if I just carry on with my usual eating and only a few treats I should be okay. They don't think it's a big baby because its head is average sized; it's just its stomach that's like its mum's. When I saw the midwife last week she showed me this page in the book, it's the birth plan. She said it doesn't normally go to plan but I should try to put some stuff down on it. I find it quite hard though, it's not like planning a wedding where you know you have to have guests and you have to have your dinner and find a minister. I know I'm going to go into labour, I'm not sure what kind of pain relief they'll be able to give me. And then they're all the different types of birth as well, not that I can have a water birth even if I wanted to. I'm sort of in denial, you know, once you start planning it, it's actually going to happen.

3 months after childbirth

After having such a good pregnancy my blood pressure went up when I was just over 39 weeks pregnant. My midwife sent me in to the hospital and they said because I was so near to my due date they wouldn't start me on medication they'd just induce me. It took 2 pessaries to get things going. When she gave me the second one she said: "right then we're gonna have to try you with another one, but we're gonna have to encourage you to walk, just go walk lots, go on the birthing balls and stuff like that just to encourage your baby to come down the way." Eventually when my cervix was 3 centimetres dilated they sent me to the labour ward and the anaesthetist came in and said: "do you want your epidural now or do you want to wait for a while?" I was like "can we wait a while?" I didn't fancy being on the epidural for so long.

Everyone was really nice on the labour ward and they were fine with me trying on my own for a bit before having the epidural. When it got really sore the graph showing the strength of the contractions was still only at 37. The midwife told me that it could go up to 120! That told me it was time for the epidural, but just at that point the baby's heartbeat started to slow and the consultant came in and said: "we don't know what's wrong with the baby but its heartbeat's dropped and obviously we can't take any chances". By that time I was so groggy I was surprised that they asked me to sign the forms. Anyway, unfortunately, I had to have a spinal block because I hadn't had the epidural early enough.

You're numb for 24 hours so I was really surprised when they asked my husband to leave when I couldn't even move myself up the bed never mind lift the baby up. I felt really helpless, especially when I had to keep ringing the bell and ask the midwife for something. You'd think they'd just give you a private room so your partner could stay. Anyway, once I could move again I made up for it and impressed the midwife when I managed my shower on my own, she said I should have waited for her but I just wanted to get on with it. Later on a young girl came in and they were saying to her: "you've got to move, you've got to do things for yourself". Two of the auxiliaries carried her to the shower and the midwife said: "she's not going to be getting out of here any time soon". I don't know whether it's because I'm older but I just wanted to get on with it myself.

Now he's here, I'm going back to Slimming World®, I like the social aspect of it. I was thinking back on my pregnancy and about having more children. When I first saw the midwife and found out that I had to see the consultant I thought: "oh my goodness I must be really fat" later on I realised that they work it out on your height to weight ratio, so I'd only just come onto their radar. I think I'm not so interested in losing 3 stone or anything like that I just want to lose enough so that my BMI is under the cut off for obstetric care. I think that's 30, so if I can come in under 30 then that will be fine. Although I really enjoyed having all the extra scans, I did find trailing back and forward to the hospital difficult, and I don't know how I'd do that with an older child to look after. I felt a bit guilty getting the extra scans, nice as they

were. I don’t know, maybe if all mums got their weight down before pregnancy then everyone could have an extra scan not just the big mums.

Appendix 22: Angie's monologue

Early pregnancy

I'm so lucky with the midwife I've got: she's one of the good ones, she's really caring and doesn't go on all the time about my weight. They're not all good though. My friend had a baby when she was 16 and the midwife said to her that it might not have been so painful if she was older. What's the sense in saying something like that? I've been luckier than that though, my midwife hasn't lectured me about my weight or diet and she's only weighed me once.

I'm not sure how much weight I've put on since I found out I was pregnant. I've never weighed myself because I don't think it really tells you anything useful, you know, if you're all muscle you'll weigh a lot, so what's the point? Okay, I've got some fat on me, especially round my middle, but I'm really broad, I've got broad shoulders and thick legs, and I'm really strong from all the karate and skiing I did when I was younger. So I don't think I'm really designed to be skinny which is what I think they'd like us all to be. Anyway, I've been tarred with the 'obese brush' since I was about 13 or 14 which to be honest is not much fun.

Talking about this reminds me of the time I wanted to join the Special Police. I passed all the screening, except I was classed as morbidly obese. I don't see myself as morbidly obese, surely that's massive? But I'm not massive! Anyway, I was told to bring down my BMI from 30 something to 29, and they gave me a year to do it. I think I got it down to 33 and then got stuck, my mum was making me all these healthy meals, and I was trying to get her to give me smaller portions, but I just couldn't shift it. Once I got my BMI down a bit they gave me a fitness test, because of the asthma I had in the past. I failed the test though. I totally panicked; there I was running around, and being watched, and I couldn't seem to get my breath. It was just like at school; people always laugh at big people running. So I never got into the Special Police.

Occupational health are the worst, they always weigh you and you always know what's coming – "have you thought about this, have you thought about that?" Don't get me wrong, I've tried to diet and it doesn't work, so I think - "this is me, this is the

way I'm meant to be". But they've got the perception that you have to be a certain BMI. My midwife's not weighed me again since that first time, which is a bit of a relief actually. I don't fancy getting on the scales, I'm carrying a baby after all, so I'm pretty sure I'm going to weigh more than I should.

Late pregnancy

Since all the blood glucose tests came back negative I don't think they're really worried about my weight. But I've been sent up to the hospital three times now for high blood pressure. It's one of the signs of pre-eclampsia, so my midwife checks it every week. The doctor was doing it before, but it was always high when she took it, so the midwife thinks I was just scared of what the doctor would say if it was high. Anyway, despite the midwife taking it, and with a bigger cuff, eventually she said - "I've got to send you in".

The first time she sent me in I was only 20 odd weeks, so I don't think they were too worried about pre-eclampsia. After a couple of hours my blood pressure settled, so they let me home. The third time they sent me was about a week after the second time, and I had to stay in overnight. To be honest, I felt a bit of a fraud being there; I had no symptoms at all, and I felt fine, everyone else was in pain or in labour. It was awful. It was late when I arrived at the assessment ward so I knew that my partner Ali would have to leave at some point because of their 'no visitors policy'. Anyway, after he went I lay in my bed behind the curtains, and I could hear all these women in labour. It was really scary, I think 3 of the ladies beside me all got taken to the labour ward, and then more came in, and then they got taken away. I was like - "Oh my God, what is going on?" But the worst thing was that the midwives made you feel as if you wanted to be there. But I didn't want to be there, I wanted to be at home with Ali in my own bed.

I only really saw people when they came to take my blood pressure, but you hear everything that's going behind the curtains - "right we're just going to do an internal examination or a speculum", you know, all the things you hear on *One Born Every Minute*. Everyone was in pain and I was just sitting there like a spare wheel. It was really busy and I really had no idea what was going on. At one point I had one

midwife come and say to me – “we’ll get you prepped to do a speculum”. I was like “what! Why do I need to get that?” She was like – “it’s just like a smear test, nothing to worry about”. But I wasn’t bleeding, or in labour, or anything like that, so I told her - “I came in with high blood pressure”, and then she realised that I was the wrong patient.

They started me on these blood pressure tablets which made me feel really ill, but they said that was just the tablets working. They’re keeping an extra eye on me now because they say anything can be happening in the background. I think they’re more worried now than before, because it’s been mentioned so many times. But with my blood pressure being controlled by the tablets I think it’s more dangerous, because I think it’s harder to spot if I get pre-eclampsia.

A lot of the information you’re given about pregnancy doesn’t really fit together. I think they expect you to have problems because of your weight. But I don’t think it follows that just because you’re big you’ll have problems. My friend got pre-eclampsia, and she’s petite. I’ve also seen skinny people end up with massive bumps. Normal sized women also get pregnancy diabetes, not just bigger women. So it’s really confusing. But for me the worst bit about pregnancy is that you’ve got to go to the doctors for every single thing. I don’t like to go to the doctor’s unless I have to. But when you’re pregnant you have to go because you could have something serious which could harm the baby.

16 weeks after childbirth

By the time they said that they wanted to induce me at 38 weeks I was just glad that I wouldn’t have to keep going back and forward to the hospital about my high blood pressure all the time. They kept keeping me in for observation because they were worried about pre-eclampsia. I hated being in the hospital so I was just relieved to be getting it over with.

I’m not really too sure of exactly what they were worried about but I think the baby can get distressed, especially with the extra pressure from pushing if the labour takes a long time or the baby gets stuck. That’s why I had to go to the labour ward and not

the midwife unit. My community midwife had explained all this to me, she was really good, she said that because of my blood pressure, the only kind of birth I would be allowed was a planned birth in the labour ward and that I would need monitored. I wasn't too upset about having to go to the labour ward. I'm not keen on the idea of using the pool or anything like that. I'm not keen on people staring at me; I'd rather things are a bit more private. But with all the worry about my blood pressure I was glad that I'd be monitored all the way through labour.

The induction didn't work and the whole thing was really drawn out, and you're only allowed one person with you at a time. My mum supports me and Ali, so we both need her, so that was really hard. 36 hours after I'd gone into the hospital the doctor told me that I would have to have a C-section and he asked me to sign the consent. I was happy to, anything to get her out. The rest was easy really, compared to the process of the induction. They gave me a spinal anaesthetic which was really surreal. I watched the whole thing in the reflection of the theatre light; it was like an out of body experience. Finally she was out. She weighed 9lb 2oz so she was big, so it looks like even if I had waited until she was full-term she would have grown so much that I would have needed a section anyway.

Once I was on the postnatal ward they said that someone would come and tell me where everything was, you know, the milk and when to feed her and stuff like that. But nobody ever did, nobody ever did come near me, so I kept expecting this nurse to come and, she never did. No one came near you and I wasn't allowed to get out of bed or pick up the baby. I expected the midwives to help, but they didn't. I spent the first day struggling to stay awake and by teatime I phoned my mum and told her that there were no bottles or anything, and she's hadn't been fed or changed all day. My mum phoned the ward and then a midwife came to talk to me. She was really nice and explained everything and brought me the milk. It was really odd, one minute they're all telling you what to do then as soon as the baby's born they just disappear.

I soon got into a routine after she was born. I had some problems with a wound infection, which took ages to heal, and then got infected. At my postnatal check-up my blood pressure was high again and I was sent to the hypertension clinic. It was there that I had an experience with a doctor that was so humiliating that I couldn't

even tell Ali about it. I don't think I've ever felt so belittled, and in front of other people too. Honestly, I can hardly bring myself to relive how I felt after what the doctor said to me.

The registrar had taken my blood pressure and told me that it was fine and I could wean myself off the tablets. Then the consultant came in with a student and gave me the usual spiel about blood pressure going up and down. Then he said to me - "you are watching your weight though aren't you?" and I said – "yeah, I watch my weight", he was like – "oh, really?" So you could tell he didn't believe me. I told him that my wound was still healing and I was busy and he wanted to see my scar. He looked at it and asked me if I was cleaning it everyday, so you could tell that he thought I wasn't. I was so embarrassed. His parting comment to me was – "the sooner you get the weight off the better and maybe next time we'll be thin from the start".

I left in tears.

It knocked me back quite a bit, I couldn't even talk to Ali about it, I was upset and angry at the same time. I'd had this surreal birth which wasn't really like experiencing a birth, so I didn't feel that I'd given birth. I was trying to bond with the baby and she was screaming with colic, and I felt she was rejecting me. I was trying to build myself up and then he knocked me down, he made me feel that it's my fault for having high blood pressure and my fault for everything that's happened. Anyway, I stopped taking the blood pressure medication, I didn't see the point, I was put on them because I was pregnant and she's here now so there's no danger to her and I feel fine.